www.fifehealthandsocialcare.org

Fife Health & Social Care Partnership

Annual Report 2020-21

NHS Fife

Supporting the people of Fife together

Fife Council

Contents

A message from our Chair

Cllr Rosemary Liewald
Chair, Fife Health & Social Care Partnership Board

I want to thank our staff, partners, communities, and colleagues from the independent and third sectors and the 'Team Fife' approach adopted in response to the Covid-19 pandemic, demonstrating integrated working at its heart. Their dedication, commitment, and professionalism to care for and support the people of Fife has been extraordinary.

During 2020/21 we have had to respond to unprecedented challenges across the whole health and social care system, and wider society from the Covid-19 pandemic. We all hoped that by now we would be seeing a light at the end of the tunnel, however demand on services continues and we have had to respond to these challenges by looking at new ways of working to ensure the health and social care needs of the most vulnerable people in our communities are met.

This is the fifth annual report for the Fife Integration Joint Board (IJB) and within it we look back over the last year (2020/21). We consider progress in delivering the priorities set out in our Strategic Plan (2019-22), with key service developments, achievements, and areas for improvement. Within this report we also review our performance against agreed strategic plan priorities, as well as the National Integration Indicators and those indicators specified by the Ministerial Strategic Group (MSG) for Health and Community Care.

There's no doubt that the pandemic has had an impact on what we do every day. To respond to the pandemic we have had to work differently to ensure the needs of those we care for and support are met, including using technology much more. It has also meant that we had to pause certain services and activities to allow us to deal with any emerging priorities.

There is much we can be proud of over the last year and we have made improvements in a number of areas. We have also learnt a lot over this period, working together as 'Team Fife' to ensure that we continue to meet the needs of service users, whilst utilising learning from staff and those who use our services to continue to develop and innovate in our delivery of services.

I'm incredibly proud of Fife Health & Social Care staff in driving forward programmes of improvement and transformation aligned to bringing services closer together to improve health and social care outcomes for the people of Fife. Ensuring we use our resources effectively and that services can be mobilised and re-mobilised to meet the demands of the pandemic and beyond. The flexibility shown by staff to be re-deployed into different roles to support priority areas is really humbling and highlights how lucky we are to have such a committed workforce.

We continue to develop our 'Home First' strategy, which is a key priority, to ensure that people who have been in hospital return home or to a homely setting as soon as it is safe to do so. This is monitored daily and teams across health and social care are working extremely hard to make sure there's a person-centred approach to this.

There has also been a huge amount of work done by teams to support the care at home service internally, and with our external providers to look at options and solutions that can maximise capacity and availability throughout Fife.

Looking at the report you will see how much has been achieved over the past year across the Partnership and I'm very proud of this and although there's more we can do, we are starting from a great base to build on.

On another note, my time as Chair of the Fife Integration Board is coming to an end. The three years in this post has gone by really quickly and I have enjoyed the role and being part of improving health and social care in Fife. Christina Cooper will be taking up the Chair role in October and I will be supporting as Vice Chair. I will still be involved with the board and partnership and working together towards achieving the best health and social care outcomes for the people of Fife.

Foreword

The demand on services across the whole health and social care system is unprecedented and ensuring we deliver good and safe services is a team effort. We couldn't do what we do without the support of our dedicated staff, our partners NHS Fife and Fife Council, colleagues from the third and independent sectors, carers and our communities, and I want to thank each and every one of you. It's by working together that we will continue to progress with integrating services and ensuring we care and support people in Fife to live the best lives they can.

I don't think any of us imagined that we would still be living through a pandemic, however, we are. Covid hasn't gone away, and we are reminded regularly how quickly the virus can spread and how we need to be able to respond to emerging priorities with flexibility to ensure those people who are most vulnerable are cared for and supported. The work achieved nationally and locally with the Covid-19 vaccination programme and the testing programmes have made a huge difference and I want to thank everyone involved, including our communities, for making this happen. This Covid-19 vaccination programme was the biggest vaccination programme we have ever been involved in and we have done an amazing job.

Living and working through a pandemic has meant some services have been delivered differently and we have learnt a great deal including the importance technology can play. We've also shown how important integration is and what can be achieved by working together with a common goal of providing the best person-centred care and support we can for our communities to thrive and live the best lives they can.

In our fifth annual performance report, we continue to progress with integration. Services delegated to the Partnership have been restructured into new portfolios supported by a new Senior Leadership Team. Linking services that work together in the same portfolio will help to support our vision for the future and improve on our performance against our strategic plan priorities and the national outcome indicators.

We have achieved a great deal over the past year, however there is more we can do. In the Partnership we have an aspiration to be one of the best performing partnerships in Scotland, and we can only do this by continuing with our integrated approach to service delivery. It's by listening to everyone we work with and support, using our resources well and progressing with transformation that we will be sustainable now and in the future.

Thank you again for your support.

Nicky Connor
Director of Fife Health & Social Care Partnership and Chief Officer, Fife Integration Joint Board

Introduction and Background

Welcome to the fifth annual report from the Fife Health and Social Care Partnership.

This report provides an update on progress against our Strategic Plan 2019 – 2022 which was published in August 2019.

Our Vision

To enable the people of Fife to live independent and healthier lives.

Our Mission

We will deliver this by working with individuals and communities, using our collective resource effectively. We will transform how we provide services to ensure these are safe, timely, effective, high quality and based on achieving personal outcomes.

Our Values

- Person-focused
- Integrity
- Caring
- Respectful
- Inclusive
- Empowering

Fife's Population

In 2018, Fife was home to an estimated 371,910 people. By 2043 this is expected to decrease by 2.1% to 364,164.

2018

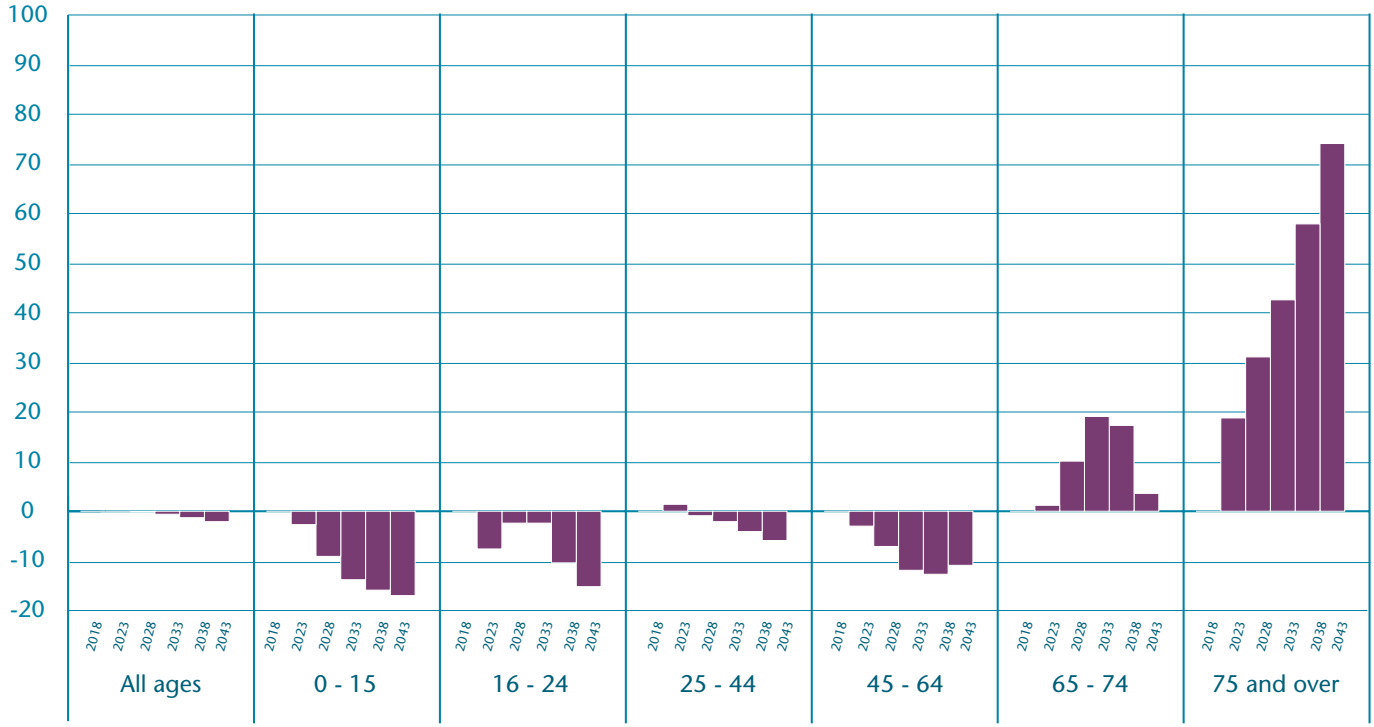
370,910 people

	2018	2043	
0-15	64,473	53,522	-17%
16-64	231,847	209,218	-10%
65-74	75,590	104,956	+34%
75+	32,754	57,026	+74%

2043

364,164 people

Projected percentage change in population by age group until 2043



Our Performance

Our latest Strategic Plan (2019 – 22) defines five Strategic Plan Priorities:

1. Working with local people and communities to address inequalities and improve health and wellbeing outcomes across Fife
2. Promoting mental health and wellbeing
3. Working with communities, partners and our workforce to effectively transform, integrate and improve our services
4. Living well with long term conditions
5. Managing resources effectively while delivering quality outcomes

These link directly to the nine National Health and Social Care Health and Well-being Outcomes

1. People are able to look after and improve their own health and well-being and live in good health for longer
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
3. People who use health and social care services have positive experiences of those services, and have their dignity respected
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5. Health and social care services contribute to reducing health inequalities
6. People who provide unpaid care are supported to look after their own health and well-being, including to reduce any negative impact of their caring role on their own health and well-being
7. People using health and social care services are safe from harm
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
9. Resources are used effectively and efficiently in the provision of health and social care services

The following sections outline the Health & Social Care Partnership's performance and progress against these outcomes and our strategic commissioning intentions.

The national indicators we can report on are presented in Appendix 1.

Please note there are a few of the 23 national indicators not available for 2020-21 period owing to the way in which these are collected, verified and released. The data reported are against core indicators and are for the period the most recent data is available. Some indicators may be provisional and subject to change.

Priority 1
Working with local people and communities to address inequalities and improve health and wellbeing outcomes across Fife

We are committed to ensuring that people are empowered to make their own informed choices about how they will live their lives and what outcomes they want to achieve. Planning for preventative action can have a positive impact on improving health and reducing inequalities and can reduce the demands for health and social care services.

Locality Planning

Although we had to pause all of locality Core Group work and meetings due to Covid-19, work has still been happening in the background through virtual meetings with our Chairs and Senior Leadership Team. September through to November saw us finalising our refreshed locality plans, focusing on work that we can realistically remobilise through 2020/2021, taking into account the Covid-19 restrictions.

Our remobilising priorities see us focussing on wellbeing and social isolation, living well with long term

conditions, supporting mental health, carer support, H&SC public representation. We have been busy updating our locality website pages, ensuring that all documents and plans are updated to reflect our remobilisation route map.

For further information regarding the priorities that H&SC Locality Planning will be delivering in our seven locality areas, have a look at the following weblinks and click on the 'Getting to Know …' document within each page.

- www.fifehealthandsocialcare.org/cowdenbeath/
- www.fifehealthandsocialcare.org/dunfermline/
- www.fifehealthandsocialcare.org/glenrothes/
- www.fifehealthandsocialcare.org/kirkcaldy/
- www.fifehealthandsocialcare.org/levenmouth/
- www.fifehealthandsocialcare.org/north-east-fife/
- www.fifehealthandsocialcare.org/south-west-fife/

Fife Wide Progress Updates

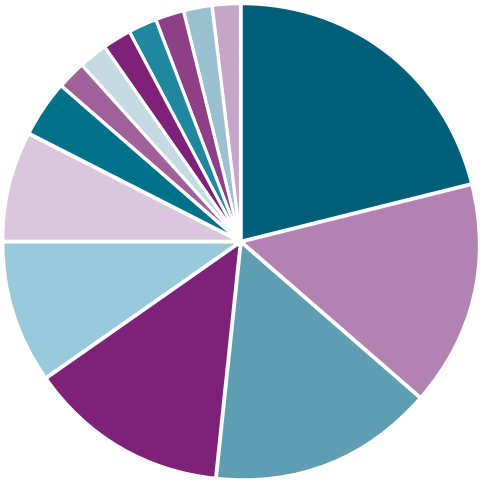
The Well Points

In March 2020 all Wells ceased face-to-face contact due to the COVID-19 pandemic. A Well Remobilisation Group was established in August 2020 to progress the Wells and restart in a safe and secure environment for both staff and public. The Well was remobilised in November 2020 using Near Me software as a tool to provide virtual access for the population of Fife. A phone line was set up to support the population of Fife who may not have access to technology or internet or feel confident enough to use the virtual Wells. A core team for each locality was established with staff from Adult and Older Adult Locality Teams and Fife Forum Local Area Coordinators.

During the period 25 Nov 20 – 31 Mar 21 we received 52 enquiries through "The Well Near Me".

Most enquiries coming through The Well have been in relation to Mental Health, Financial Support/Benefits and Community Support. Social care, Care at Home and Housing are also high on the list of enquiries.

Reason for visiting The Well



Benefits	11 (21.15%)
Housing Support	8 (15.38%)
Mental Health	8 (15.38%)
Community Support	7 (13.46%)
Care at Home	5 (9.62%)
Social Care	4 (7.69%)
Shopping Support	2 (3.85%)
Carer Support	1 (1.92%)
Community Alarm	1 (1.92%)
Council Tax	1 (1.92%)
Occupational Health	1 (1.92%)
Physical Health	1 (1.92%)
Social Isolation	1 (1.92%)
Social Work	1 (1.92%)

Social Work Contact Centre

The Social Work Contact Centre is Fife's front door to the Health and Social Care Partnership. Throughout 2020/2021 the Social Work Contact Centre have afforded flexible approaches to the challenges faced resultant to COVID-19 and have driven forward:

- a single point of access for new Social Work and Social Care enquiries (people and professional).
- improved outcomes for our people by enabling the delivery of integrated services.
- improved consistency and quality of service by providing a focused approach to communication across the service.
- supported an early and proactive approach to delivering the right service at the right time.
- raise the standards of service response by ensuring effective end to end processes.

The Social Work Contact Centre have developed strong links with The Well and will continue to strengthen this relationship to support and enable an early and proactive opportunity for

people to plan and make informed choices about how they live their lives.

To drive the Health and Social Care Partnership vision forward, promote an integrated service at the front door and reduce pressure on health and social care services, the Social Work Contact Centre next steps will be:

- Continuing to provide accessible information, advice and guidance
- Reviewing the current website and taking forward an enhanced opportunity for online referral and engagement
- Continuing to strengthen a coordinated approach to people receiving the right support, at the right time, from the right place.
- Ensuring we are proactive in responding to the needs of the people in our community and respond at the earliest time to promote individual and community resilience, best outcomes and avoid crisis situations.
- Working together to creatively design new ways to deliver the best possible care and support at the front door.

Planning with People

We have been working to recruit three Public Engagement Officer posts to engage with the public, communities, community organisations, public and private bodies to develop effective processes and mechanisms to enable people to be involved in planning and decision making of H&SC Services.

Levenmouth Locality Progress Update

Levenmouth HSCP Drug Deaths Update

Fife Alcohol & Drug Partnership (ADP) Support Team has identified a significant number of Fife's total drug deaths have been occurring in the KY8 Levenmouth area over the past three years. In 2019, as many as 22 of Fife's 81 deaths happened in the area.

In partnership with the Levenmouth Health & Social Care Partnership Group, the ADP through its Overdose Prevention & Drug Death Monitoring (OPDDMG) subgroup, is developing strategies to reduce the acceleration of such deaths, stabilise their frequency and ultimately reduce their overall occurrence. These outcomes now form part of the Levenmouth Locality Plan and are a feature of the OPDDMG work plan.

In addition to the Levenmouth HSCP, the ADP has engaged with the Levenmouth Multi-Disciplinary Team in an attempt to identify key stakeholders who will contribute to the strategic aims outlined above. Managers and representatives of ADP-commissioned services who have a prominent presence in the area have also been consulted as part of a wider consultation exercise which will include local Councillors, Police Scotland, NHS Fife Health Promotion Team and representation from local front-facing services such as pharmacies and foodbanks.

The ADP Support Team are developing a comprehensive response which will also include contribution from the ADP funded Near-fatal Overdose Team who provide assertive outreach to those who experience an NFO across Fife. Key to the success of this work is developing links with the local community to more effectively deliver targeted harm reduction messages such as overdose awareness, naloxone provision and distribution, as well as reaching families and

friends in addition to those most at risk of overdose and death.

A number of opportunities have been highlighted and the ADP has identified a number of objectives including, but not limited to:

- Increasing the presence of drug services embedded within the community.
- Growing educational opportunities on harm reduction and overdose to individuals, families and friends, and key local professionals.
- Enabling easier access to the wider gamut of ADP-related service options.
- Highlighting the existence of key local services to the community.
- More support for family members.
- Wide availability of injectable and nasal naloxone and injecting equipment.
- Reduction of stigma associated with problem drug use which prevents users and their family from accessing services and harm reduction messages and equipment.
- Faster access to Medication Assisted Treatment (MAT) such as methadone and buprenorphine.

People with lived experience will also play a key role in developing and monitoring a response for Levenmouth. The ADP Lived Experience Panel (LEP) has representation on all consultation groups and the nature of the problem has been discussed widely at LEP meetings. The lived experience of those on the LEP who grew up in the area is invaluable in designing a response which will be meaningful and deliverable.

Kirkcaldy Locality Progress Update

Type 2 Diabetes Prevention & Reversal within the Kirkcaldy locality

We are delivering targeted weight management interventions for adults living with or at risk of Type 2 Diabetes (T2D) across Kirkcaldy Locality through a group education programme which aims to support people at high-risk of T2D to prevent or delay onset of the condition.

Through structured education, Let's Prevent Diabetes supports people to make personalised lifestyle and behaviour changes, shaped around the group's local and individual needs. The programme is six hours in length, attended by up to ten people and led by two trained educators. Participants learn about the risks and implications of developing T2D, along with how to make lifestyle changes to prevent its development. This pragmatic intervention helps people to reduce their HbA1c and LDL cholesterol levels, through reducing sedentary behaviour. We do this through encouragement, peer support and coaching to reach self-determined goals.

Let's Prevent is at quite an early stage in Kirkcaldy, but we are already seeing some useful patient engagement. Currently, we are controlling the intake of patients while the service builds capacity - the GP surgeries are identifying the patients based on historical blood test results and the Let's Prevent team are then inviting them along and requesting medical summaries from the surgeries to support this.

Supporting those with Sensory Impairment

The Deaf Communication Service (DCS) is a small service with a team of 3 Development Workers and who provide support to people who live Fife wide who are Deaf, deaf, Deafened, Deafblind or who are Hard of Hearing.

The team deliver on two National Strategies. The BSL National Plan (Fife has a Local Plan) and the See Hear Strategy and work within these two strategies to meet the recommendations of both. The key to success is the person-centred local partnership between statutory and third sector agencies. The overall strategic intent of both Fife strategies is to deliver improved health and social care outcomes for the BSL communities, which includes accessibility to information and services that are sustainable through long term investment and supported by new models of service provision.

The Team as small as they are, have been delivering effectively and timeously on both the Fife Local BSL plan the See Hear Strategy. Prior to the pandemic we were actively working towards meeting our priorities. The following is not exhaustive of the activities undertaken by DCS:

- Working in partnership with NHS Audiology to determine referral route from audiology screening through our Pop up Surgeries in The Wells.
- Participating in a lottery funded project with Deafblind Scotland to increase community engagement and develop a data set of people living in Fife with deafblindness to support future service development and training. This is progressing slowly due to the pandemic. A bi-annual Deafblind community involvement day is to be introduced in order to identify and bring together Deafblind people who live in Fife and introduce them to a wider range of resources.
- Working with CAHMS to increase awareness of Scottish Mental Health Services for Deaf People. This is a huge gap in service, with DCS leading on engagement through a mental health conference with the Scottish Mental Health Service for Deaf People, the first of its kind in Scotland for both professionals and users and funded through Fife SeeHear funds.
- Facilitating training for Sam's Café in supporting adults with a hearing impairment or who are Deaf/deaf.
- Working with NHS Equalities for Deaf people to access Psychology Therapies. Testing of the site has proved positive with feedback.
- Setting up a Cochlear Implant Support Group, funded from Fife SeeHear funds to continue post Covid-19.
- Working with Hearing Link on the Halo Project; early intervention for newly diagnosed hearing loss to augment current services, to continue post Covid-19.
- Working with Housing (Housing Pods) See Hear funded. Further follow up post Covid-19.
- Partnership work with NHS Equalities, engaging with the Deaf Community, supporting any issues with accessibility to health services or information.
- Working in The Wells, Pop up Surgeries in Local Libraries.
- Working with Ostlers care home staff by training them on Hearing Screening. This augments regular optician visits and Hearing Champions have been identified for the other 7 Older People homes/villages. This work will continue post Covid-19.

- Working with Fife Sheltered Housing complex in delivering Communication boxes, contact has already been established and boxes have been delivered. This will require follow up and plans to establish Pop up clinics in the sheltered housing complex will happen post Covid-19 when it is safe to do so.
- Training for staff during Covid-19 have included sessions with Police Scotland (Fife P Division) where 17 officers received Deaf Awareness and BSL Taster sessions (socially distanced) and 20 NHS staff were provided with BSL awareness sessions in April 2021.
- DCS have developed alongside workforce development a BSL SIGNATURE Level 1&2 Course to start in September 2021 as part of the BSL Local Plan. DCS will receive registration as a centre imminently.
- BSL Awareness/Interpreter Awareness training on Oracle by DCS Tutor
- In order to further support the diverse range of needs in the deaf community, the team have updated their own skills by attending Islamic Sign Language awareness, Deafblind manual level 2, 3rd Party reporting for adult protection/support for Deaf people experiencing Domestic Violence/abuse.
- Developed a Young person event for secondary school students with a sensory loss to feature speakers with lived experience of paid employment options and volunteering.
- Worked with Education on tutoring youngsters in BSL
- Partnership working on progressing the BSL Local Plan for young people and their parents.
- Developing an effective communication strategy that is accessible and promotes ongoing work between DCS and communities on the progress of the BSL Local Plan/See Hear Strategy. A newsletter, leaflets and promotional materials have been developed to support this aim. DCS also have a Social Media presence ie Facebook, Twitter, Youtube channel which has been highly effective during Covid-19 Lockdown(s) as there was evidence the deaf community were largely unaware of the ongoing changes to restrictions.
- Made available 148 accessible video clips for Deaf community and any Fife BSL Colleagues. Clips include, Adult Protection, NHS Updated Information, FHSCP Updates, Police Scotland Updates, Fife Fire Service Updates, but most importantly supporting people to understand the importance of the ongoing changes to restrictions during Covid-19.

The service adapted to Covid-19 by offering support in a different way. Drop In which is normally available 3 afternoons per week for people who present to the office for support for a range of difficulties was no longer an option however referrals and contacts continued.

For the period April 2020-31st March 2021 there were 1309 contacts to the team for a myriad of support, which includes requests for technology or communication equipment.

From the onset of the pandemic, it became evident that people with a lived experience of being Deaf or who rely on British Sign Language (BSL) as their first language found the restriction(s) pathway difficult to navigate. Fife Police referrals also increased, regarding concerns about restrictions being misunderstood. To support this the team translated the essential Covid-19 guidance to short clips and videos on DCS YouTube and the DCS Facebook pages. Additionally, home visits were prioritised to those requiring critical support and advice or who required essential repairs to communication equipment.

An increase in adult protection activity was also evident in the Fife Deaf/deaf community as people appeared to be more vulnerable to exploitation. Information was passed to relevant area Teams, however due to communication difficulties some cases have been retained by the DCS team for ongoing advice and support.

There has been an increased demand for support to access foodbanks, supporting CARF appointments or benefits enquiries. One example is support offered to a Syrian gentleman recently estranged from his family who communicated with a mixture of Arabic sign, stimulating the requirement to seek out relevant training for the team. The team also supported the gentleman to access support from an Asian deaf group in Glasgow and sourced donations for a laptop.

Next Steps

- Priority will be to continue to provide information accessible for Fife BSL community
- Young Person Event to support Children and Young Adults' transition from school/education to work/employment
- Work with Deafblind Scotland to increase community engagement and develop a data set of people living in Fife with deafblindness to support future service development and training.
- Work with CAHMS to increase awareness of Scottish Mental Health Services for Deaf People.
- To continue to improve on and develop further links with Fife Police and NHS Equalities re BSL and Deaf awareness training for Fife employees
- Work with Workforce development a BSL SIGNATURE Level 1&2 Course to start in September 2021 as part of the BSL Local Plan. DCS have this week received Centre registration so this can now be progressed
- Continue to work with NHS Equalities to ensure communication support at critical times

Helping families through The Family Nurse Partnership (FNP)

This is a Fife-wide licensed, voluntary, evidence based, early intervention home-visiting programme offered to all eligible first-time mothers aged under twenty.

Family Nurses visit FNP clients approximately fortnightly from very early pregnancy until their first child is two years old, delivering the Universal Health Visiting Pathway throughout the time that FNP clients are enrolled on the programme. Nurses are specially trained, including the use of motivational interviewing (MI). MI is designed to strengthen motivation and commitment to identified goals and behaviour change.

Multiple studies have identified better outcomes for children of mothers who enrol with FNP compared to comparative cohorts, although FNP clients consistently say that it is the therapeutic relationship they develop with their Family Nurse that they value the most.

Approximately 70% of FNP clients reside in the most deprived data zones in Fife, demonstrating that FNP is meeting the needs of the most deprived young first-time parents in Fife.

During the pandemic the majority of health and social care as well as voluntary services were not able to meet with families directly, reverting to the use of video calls via Microsoft Teams. This impacted on some clients' ability to meaningfully engage in meetings or activities due to their lack of resources.

The receipt of the laptops and/or WIFI helped to reduce families' isolation and poor mental health experienced during the pandemic, enabling them to participate in online support and mother and baby activities facilitated by local voluntary groups such as Fife Gingerbread and Homestart. It also facilitated their engagement in important child wellbeing or child protection meetings all of which have taken place via video link throughout the pandemic. Before receiving the equipment clients were using unreliable internet connections via mobile phones. The main challenge for this activity was ensuring that the clients were in receipt of their laptop and WIFI within the 30 day period expected by Connect Scotland.

In January 2021 FNP applied for and received 23 laptops and 25 WIFI connections from Connect Scotland which were shared with clients who had no access to IT equipment or the internet.

Throughout the pandemic Family Nurses have also continued to support FNP families to access the Money Talks Team, provided by the Citizen's Advice Network, Scotland. Family Nurses make referrals to the service and support clients who find engagement with other services difficult, for example being with them at home when the Money Talks Team phone to offer advice.

Next steps

Continue to apply for appropriate grants as they become available. It is anticipated that Connect Scotland will offer the opportunity to apply for laptops and WIFI again in the near future.

Children & Young People's Community Nursing Team

ADHD Nurse Service

- Over the past year, the ADHD service have managed to continue offering support and advice to young people and their families, despite the Covid-19 restrictions, by adapting and continuing regular reviews via the telephone and Near me.
- The ADHD Nurse team have expanded their service and now have 7 nurses across Fife who will provide support to medical staff and joint working with the wider ADHD team. By having nurse support throughout Fife there will be a better equity of care across the service.
- The nurses now have a phone line which is manned on a rotational basis providing advice and support to families and the multidisciplinary team.
- The ADHD Nurse service has 4 Sleep Councillors at present. Two of our ADHD Nurses have developed a SWAY package around sleep for our families to access (available on Hands On Scotland and Mood Cafe web pages). Due to the pandemic, we have not been able to run our group sessions around managing sleep so the sleep SWAY will allow families to access good quality information and advice during this time until we can return to having face-to-face groups.

- The ADHD Nurses are now paperless. At the end of March 2020, we moved over from paper records to MORSE, an electronic note system. This was extremely helpful in terms of us being able to access notes from home and still be able to run our clinics (albeit modified) This has also meant information can be shared more easily and improving safety.

Next steps

- A further ADHD Nurse will complete the Non-medical prescribing course this coming year.
- Remobilising the ADHD Nurse service will begin with a blended way of working. The ADHD nurses will work part of their hours from home with telephone/Near Me clinics and the rest of their week with face-to-face clinics in their areas.
- The ADHD Nurse service are currently running a telephone audit with families to obtain feedback around our current service and the experience they have had

Children and Young People's Continence Team

Despite face-to-face contact stopping in March 2020 due to the Covid-19 pandemic, the team were able to continue to provide a service to all the children and young people in our care, through modifying interactions. Appointments were offered by telephone or virtual appointment and continued to allocate adequate time to complete comprehensive assessments and review consultations. We have continued to work within our agreed waiting times for initial assessment, and treatment reviews within the enuresis/wetting clinics for our service.

The Children and Young People's Continence Service won the "Improving Life Experiences Award" from Children's Health Scotland on Friday 4th September 2020

This acknowledged the work they have done in making a difference to the health and wellbeing of children and young people in Fife.

The judges felt that the team was making a significant difference to the confidence and resilience of children and young people, so they are better able to deal with their difficulties.

An audit of the service provision during lockdown showed 88.5% of patients felt service level was maintained; 4% had no past experience of the service to compare to; and 7% stated they felt less supported but acknowledged they had not contacted the service for additional help outwith their routine scheduled appointments. The excellence of quality-of-service provision was rated at 90.4% for this time period. We were aware that we were not always able to communicate directly with the child /young person during this contact, however in audit responses to the question "would you prefer that the majority of future appointments are offered by telephone consultation for the enuresis clinic service?" 53.8% of parents answered yes; 42.3% no and 3.8% 'don't mind'.

Next steps

- Funding/approval for another Band 5 staff nurse has been submitted to ensure the team continues to be able to support children and families with day, night and secondary wetting issues, and soiling and constipation problems.

Children and Young People's Special School Nursing Services

- Special schools remained open during Covid-19 lockdown
- Nurses continued to offer a safe place for children and young people with a learning disability and / or a complex health care need
- Case file audits carried out
- Children / young people's flu vaccines offered by school nursing staff to reduce school footfall

Next Steps

- Recruitment to the team to fill resignation gaps
- Commencement of a sleep clinic within special schools run by nursing staff
- Commencement of a constipation clinic within special schools run by nursing staff

Children's Community Nurses Team (CCNs)

- The CCN team are now based out of two Health Hubs which we have established in Leven and Kelty Child Development Centres, each with a clinical room to carry out nursing care interventions for children in the community. Home visits continue with risk assessments and appropriate PPE in place.
- We have established bigger more robust Teams by co-locating with the Child Development Centre (CDC) staff which has improved team working, communication and professional relationships as well as increased support for staff and shared learning opportunities.
- Throughout lockdowns and all of the challenges presented by the pandemic the CCN team have maintained a high level of support to families with complex health needs and delivered high quality nursing care.

Next Steps

- The Hubs continue to function effectively with social distancing and infection control measures.
- Home visits to children continue in the community to maintain care and support with appropriate PPE.
- Plan to explore expansion of the team due to increasing caseloads and challenges.

Health Visiting and Breastfeeding Service

The Health Visiting Service works in partnership with other agencies and services to complete ongoing health and development assessments to provide support and advice to parents/carers of children from pre-birth to pre-school. The skill mix of Health Visitors, Nursery Nurses and Health Care Support Workers work together to provide a unique contribution to Getting It Right for Every Child (GIRFEC) through home visiting. We have continued to deliver a service throughout COVID-19 with reduced staff where the most vulnerable children have continued to be seen and supported. We have adapted to new ways of working remotely with our partners in education and social work to support health and wellbeing. The use of Microsoft Teams has been instrumental in maintaining links with partners and attending wellbeing meetings, children's hearings etc.

Breast Feeding Support Service

The Breast-Feeding Support Service contacts all breastfeeding mothers shortly after discharge from hospital to offer support in establishing and maintaining breastfeeding. This support can be by telephone, home visit or email / text messages. The service has continued to be delivered during Covid-19 including face-to-face support with staff in full PPE.

Next Steps

Fife Implementation of the National Health Visitor Pathway in Scotland

Have robust self-evaluation in line with National Inspectorate Quality Indicators, Children's Service Plan outcome measures and the Child Protection Improvement Plan

- Develop services in line with the Health and Social Care Strategic Plan and NHS Fife Clinical Strategy
- Continue to fund annexe 21 posts balanced with ongoing external advert for experienced Health Visitors from neighbouring boards.
- Team Leaders to be trained in, and provide, robust management, restorative and case supervision to HV staff.
- Continue quality assurance audits to inform programme of staff training.
- Skills mix to be trained / upskilled in early intervention for key childhood issues.
- Suite of Standard Operating Procedures / Competency Frameworks to be agreed and implemented for all staff group grades.
- Consideration given to development of new post(s) to support governance / training of staff.

Lochore Meadows Project – accessible leisure and play for all

This is a Partnership project as part of the upgrade of Lochore Meadows play park and involves Children, Young People and Families, PAMIS (Promoting A More Inclusive Society), the Children & Young People's Occupational Therapy Service, Fife Council Community Planning, Lochore Meadows, Friends of Lochore Meadows, Fife Council Access Officer and Play as One Scotland.

The project aims to achieve PiPA (Plan Inclusive Play Areas) accreditation through a plan which 'designs out' barriers to play, enables self-esteem and builds confidence as well as encouraging independence. A 4th year Occupational Therapy student has engaged with children with additional support needs (ASN) and their families through a survey to discover what they thought should be included in the upgrade to Lochore Meadows play park, to make it more accessible and user-friendly for this group of children.

Next steps

- Plans and building schedules for the park are being finalised with work due to commence in 2021.
- Promote and increase use of the 'drive deck' available at Lochore Meadows. Collaboration amongst local stakeholders identified the need to expand access to Drivedecks outwith the school environment. The Drivedeck at Lochore Meadows with its SMART computer technology is a resource that enables a person to use whatever small motor skills they have to play safely and independently alongside their siblings and peers amongst nature.

Housing

Preventing Homelessness and supporting those who are homeless or vulnerable

Throughout this challenging year the Housing service has continued working towards the priorities identified in the Strategic Plan 2019 – 2022. Key achievements during 2020 – 2021 include:

- A new service design for Housing Access has been developed with the focus on Prevention of Homelessness and to ensure that the aims of the Rapid Rehousing Transition Plan are met.
- Preventing homelessness is particularly challenging as homelessness (crisis and backlog) is increasing and there is an increasing demand for temporary accommodation. In addition there seems to be a greater number of vulnerable people approaching the Council due to homelessness.
- A range of service improvements have been developed after undertaking a 4DX Sprint exercise – insights were gathered from service users and used to improve the service.
- Increasing focus on the digital offer: advice and support – a virtual Housing Access offering is being designed to help customers have wider access to Housing Advice.

We undertook 380 Housing Advice interviews with people experiencing domestic abuse to help offer alternatives to going through homelessness.

Housing Support Service continues to be delivered via hostels and outreach services.

- A Revised Housing Access Hub Approach has been developed to promote a "no wrong door" approach. This will start with Segal House in Dunfermline.
- The Public Social Partnership (delivering homelessness services and housing support) Formal Review has been undertaken by a Housing Consultancy Company – a range of improvements have been identified.
- The Public Service Partnership has developed a Trauma Academy to deliver Trauma Informed Training and practice development.
- Assertive Outreach/Housing First pilot has been established with the Rock Trust to work with individuals who require intensive support to maintain their tenancy.
- Where customers have been successfully living in their temporary accommodation there has been a scheme to convert these into the customer's home.
- Starter/Tenancy Sustainment Packages have been offered to customers during the Covid-19 pandemic to provide furniture/white goods. Tenancy sustainment across sectors has remained high.
- Continued support through the Homelessness Liaison (Mental Health) Nurse Service. This service assists homeless people gain better access to mental health services throughout Fife. People who are homeless can refer themselves directly. The service offers interim support until accommodation issues are resolved.

Housing Adaptations

The first one stop shop has been completed at Rosewell Clinic in Lochore. This was delayed due to Covid-19 but progress is again being made.

Presently we are looking at how this will be staffed. "Mobile Room Pods" giving mockups of adapted and non-adapted rooms have been established here to allow for assessment of clients by OTs.

The Smart Life in Fife assessment system will be promoted within the one stop shop and discussions have started with ADL Smartcare to look at having more housing assessments placed on this platform.

We provided 393 permanent adaptations to properties to help people keep living independently.

The average time to undertake adaptations from approval is 23.12 days.

Next Steps

- Develop further on-line assessment tools via Smart Life in Fife
- Start running surgeries at Rosewell Clinic, Lochore
- Develop virtual Housing Advice Hub
- Develop physical Housing Advice Hub at Segal House

Supporting those with Hepatitis C

56 people were treated for HCV in 2020/21. This represents 48% of the Pre-Covid Scottish government target for Fife of 115 which is a remarkable achievement given the level of staffing support the service provided to the Covid-19 response. This included deployment of staff to acute clinical areas including ICU, and sustained and ongoing support to health protection, contract tracing and immunisation Teams. Health improvement staff also provided support to Third sector services involved in Injection equipment provision which is a key component of Hepatitis C and HIV prevention.

Our progress towards Elimination of Hep C has been maintained by:

- Continuing to initiate and treat patients assessed by the service prior to lockdown in Covid-safe ways.
- As first lockdown eased continuing the further shift in the method of delivery of service to outreach and mobile approaches.
- Building on the Winter 2019 Pop Up Testing PDSA work by increasing targeted testing in Homeless, Harm Reduction and Addition services.
- Introduction of a multi-agency inclusion forum and a separate rapid care and support group involving BBV, Homeless Mental Health and Harm Reduction and Recovery staff to address urgent and basic needs of service users for example food, finances, access to digital technology.

In March 2021 we also commissioned the Restoration charity to support people with Blood Borne Viruses. The new service operates a peer support and community connection model which has proved effective and popular among a range of excluded populations in Fife over the last 10 years.

Next Steps

- Embed the mobile and outreach model of service delivery to increase testing and treatment access.
- Continue to develop the work with homeless populations to offer increased access to basic healthcare and increased access to testing treatment and care.

Provision of Long Acting Reversible Contraception

Work towards increasing the uptake of long acting reversible contraception (LARC) among women affected by alcohol and drugs continued throughout 2020-2021.

834 Women received a coil insertion at Sexual Health Fife in 2021. A significant effort went into communications with women who were seeking a new or replacement forms of LARC during lockdown. This included phone triage and social media information and reassurance on the safe extended use of LARC for those who were due for a replacement.

The information provided on this change in the plan relate primarily to creating the conditions for women in underserved population (including people who use alcohol and other drugs) to access a range of support from a sexual health service that met their needs, built up trust and respect and involves a shift in the way statutory and third sector services work together. In some excluded groups LARC was not found to be a priority. From a health perspective a more concerning issue was the lack of update of cervical screening.

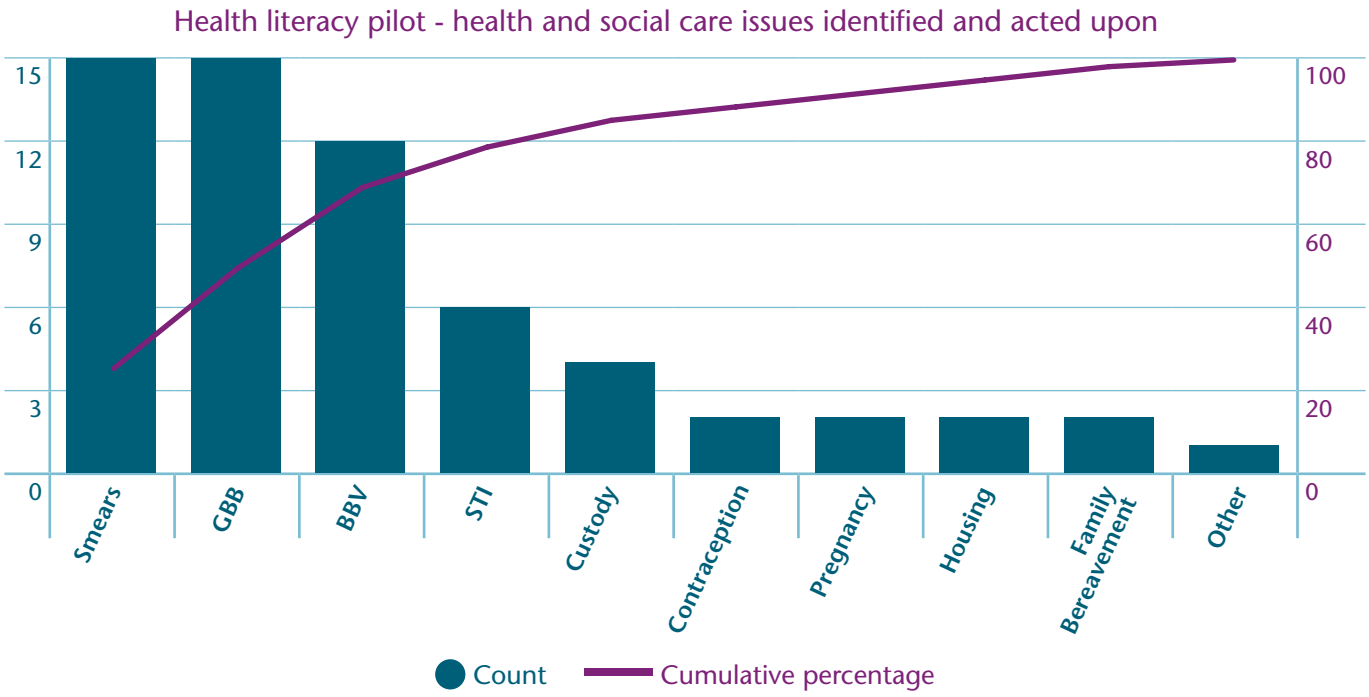
A Scottish Government funded pilot ran in Fife from 8th February to 31st March 2020 with the aim of increasing the health literacy of a group of 36 women living with disadvantage (homeless, offending behaviour, substance dependency, gender-based violence, mental health) in relation to cervical screening. The project used experience-led co-design and improvement science methodologies. The partners involved were Restoration, Scottish Drug Forum, Fife Council Criminal Justice Service, NHS Fife Services (Sexual Health Fife and Addictions) and the women themselves.

The outcomes of the work were:

- 100% of women engaged in the project had discussion about smears and other health and social care needs
- 100% of women were supported in health literacy (given information and had discussion about smears and were empowered to choose to attend clinics based on needs and preference)
- 68% reduction in the number of women who were overdue smears.

Elements critical to success were partnership working, peer support , relationship building with women and contingency management.

The co design, preparation, trust building and crisis intervention capacity of the workers involved led to a range of health and social care issues being identified and acted upon. (See following chart).



Next Steps

- Maintain and develop the innovation and redesign in delivery of sexual health services, particularly in relation to reducing health inequality.

Safeguarding Activity

Safeguarding and Protection of Children

NHS Fife/H&SCP has a duty to safeguard and protect children and young people and this remains a key priority. The Child Protection (CP) Team is a dedicated resource/service within health to promote and support optimal safeguarding practice with a key role in supporting those protecting others. Amongst its functions are representing Health at the daily Inter-agency Referral Discussions (IRD), providing support and advice, supervision, training and quality assurance.

Despite the challenges posed by Covid-19, we have managed to continue to deliver on all key functions virtually, albeit with modifications and restrictions, with the team working hard to transition CP training programmes on to MS Teams and there is now a full calendar of single agency training available to staff. Approval will be sought from the CP oversight group in summer 2021 to launch a refreshed Core CP training framework, which will include obtaining Training Needs Analysis data which will help identify any unmet learning needs from key services and enable planning.

The drive to strengthen quality assurance and self-evaluation activity remains key for Children's Services and has continued to do so this year, in the endeavour to ensure Fife's children and young people are safe and get the support and protection they need when they need it.

The provision of forensic medicals has remained unchanged throughout the pandemic. From a medical perspective the Child Protection Managed Clinical Network (MCN) oversees performance data with respect to forensic medicals, report writing etc and drives some of the improvement work and clinical protocols, which Fife team actively contributes to.

We supported children and families during lockdown through a number of initiatives including:

- the opening of Child Activity Centres for vulnerable families and children of key workers; and
- humanitarian aid to address food poverty and resourcing families to enable virtual connectivity with schools. NHS/H&SCP Children's services, in partnership with education, social work and SCRA (Scottish Children Reporter Administration) worked closely together from the outset, in order to coordinate interventions whilst minimising footfall.

Maybe unsurprisingly, the CP team experienced a significant reduction in child protection activity when Scotland went into lockdown, and as a result 2 of the nurses were deployed into health visiting for a period, where they undertook more front facing work, supporting an at that point stretched workforce.

The emotional impact on staff is inevitable, and we have benefitted from introduction of monthly restorative supervision by our psychology colleagues. This has been welcomed by the team and we intend to continue with post Covid-19 too.

From a strategic perspective the Lead Nurse worked closely with Social Work and Education in aligning interim guidance and measures that enabled a coordinated approach of targeting services towards the most vulnerable, both on an intensive but also universal (named person) level.

From a health perspective our guidance was informed by Scottish Government papers – including the Coronavirus Act, interim child protection guidance and practice guidance for community child health, the latter providing the crucial practice steer for the named persons and specialist midwives.

Due to the rapid changes to practice guidance we developed a real time chronology of national and local practice guidance and resources, available on our website for staff to access via Blink.

We ensured that national public awareness initiatives were well publicised via Blink, such as Child Protection Committee Scotland 'Eyes and Ears' (also known as 'See something, say something') as well as the various Domestic Abuse campaigns.

Next steps

- Preparation for the Joint Investigative Interview Pilot
- Implementation of the new Child Protection Guidance, published June 2021.
- Continue to embed the Child Protection Quality Assurance Framework within children's services, so that we can provide consistent, validated performance reporting, quality assurance and improvement work that all inform service delivery to further improve outcomes for children
- Gradually move from a hybrid model of working to face-to-face once it is safe to do so.
- Continue to hold monthly restorative supervision, facilitated by the psychology service.

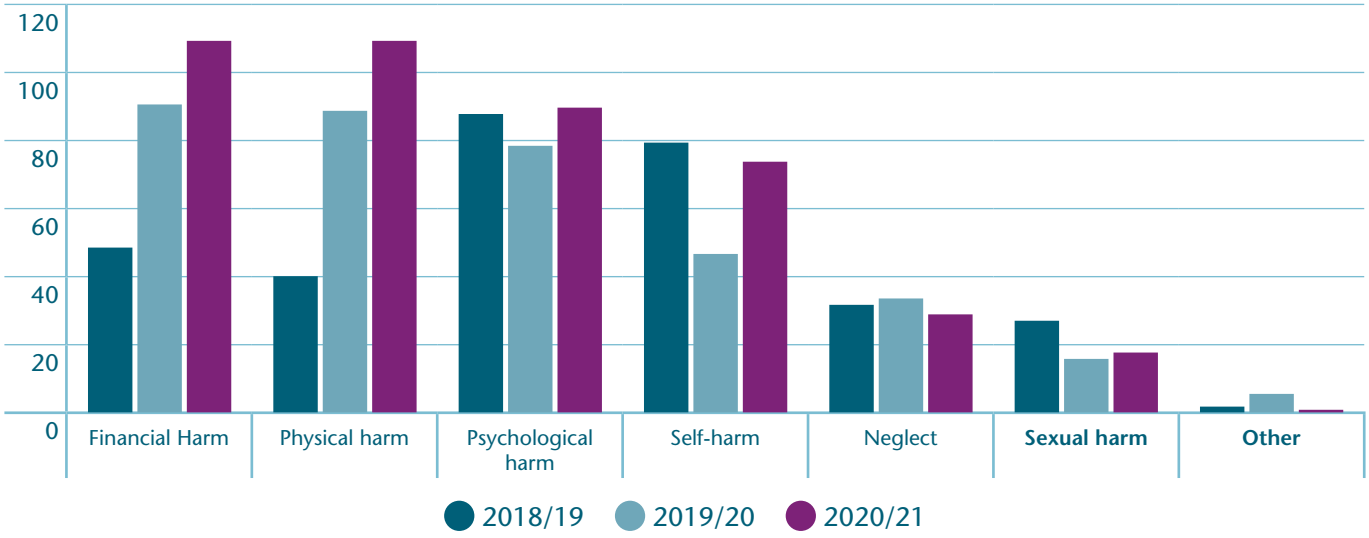
Adult Support and Protection

Adult Support and Protection is everyone's business. All Health and Social Care employees have a duty under the Act to ensure that adults are safe and supported to be able to lead independent lives. The Act places a duty on those agencies named in the Act to report harm to Social Work, with Local authorities given a statutory duty to make inquiries about the well-being, property, or financial affairs of an individual if they know or believe the person is an adult at risk and that they might need to intervene to take protective actions. Appropriately trained Social Workers, Council Officers, are delegated the duty to carry out inquiries following receipt of a report of harm and investigations as appropriate, on behalf of the local authority. The agencies named within the Act must co-operate with inquiries made by Social Work in relation to adults at risk of harm.

Key activity during the year 1st April 2020 to 31st March 2021:

- We received 2798 Adult Support and Protection reports of harm relating to 1876 individuals. Of these 29% had multiple reports of harm.
- We commenced 460 investigations; Of these 59 were subject to further AP action and 172 were subject to further non-AP action with the rest requiring no further action.
- The main types of harm recorded for cases at Investigation stage were Financial harm (25%), Physical harm (25%) or Psychological/emotional harm (21%). There has been a notable increase in the number of Investigations relating to self-harm. The chart shows the change over time in the principal harm resulting in an investigation.
- 126 cases were subject to an ASP Case Conference (84 initial and 42 review)
- We commenced 2 Large Scale Investigations.
- We started to prepare for an Adult Support and Protection thematic inspection by the Care Inspectorate scheduled to take place during the summer 2021.

Types of Principal Harm Resulting in an Investigation



Priority 2
Promoting mental health and wellbeing

We are committed to ensuring that the people of Fife can get the right help at the right time, expect recovery and fully enjoy their rights, free from discrimination and stigma. The commitments of Fife's Mental Health Strategy will require creative thinking and innovation to ensure services are fit for the future, supporting positive mental health and wellbeing for all. To succeed will require co-production across all parts of the service, with communities, with our partners in the voluntary sector, with people who use our services, their families and carers.

Locality Planning - Action 15 Local Area Coordinators

This project is Fife Health and Social Care's response to Action 15 within the current Mental Health Strategy for Scotland.

During Covid-19 We have been working to recruit nine new members of staff who will support our locality working through the Local Area Co-ordination approach and working alongside the person focusing on their strengths so that solutions can be arrived at that will help to keep people strong and connected with their personal and community resources. With continued appropriate support from the LACs and Connectors, the person will be able to address the non-medical issues that are having a detrimental impact on their health and well-being, thus hopefully preventing problems and crises, and reducing the number of times they need to see their GP.

The Project will have, by September 2021, 2 full-time equivalent LACs and 7 full-time equivalent LAC Community Connectors all of whom will receive training in Local Area Co-ordination and what this approach involves. Their purpose is:

- To support people and communities to develop their capacities and to discover, connect and create opportunities for this to happen.
- To improve health and wellbeing by linking people with sources of support within the community.
- To reduce frequent attendance to GPs.
- To reduce referrals to acute services.

Child & Adolescent Mental Health Services (CAMHS)

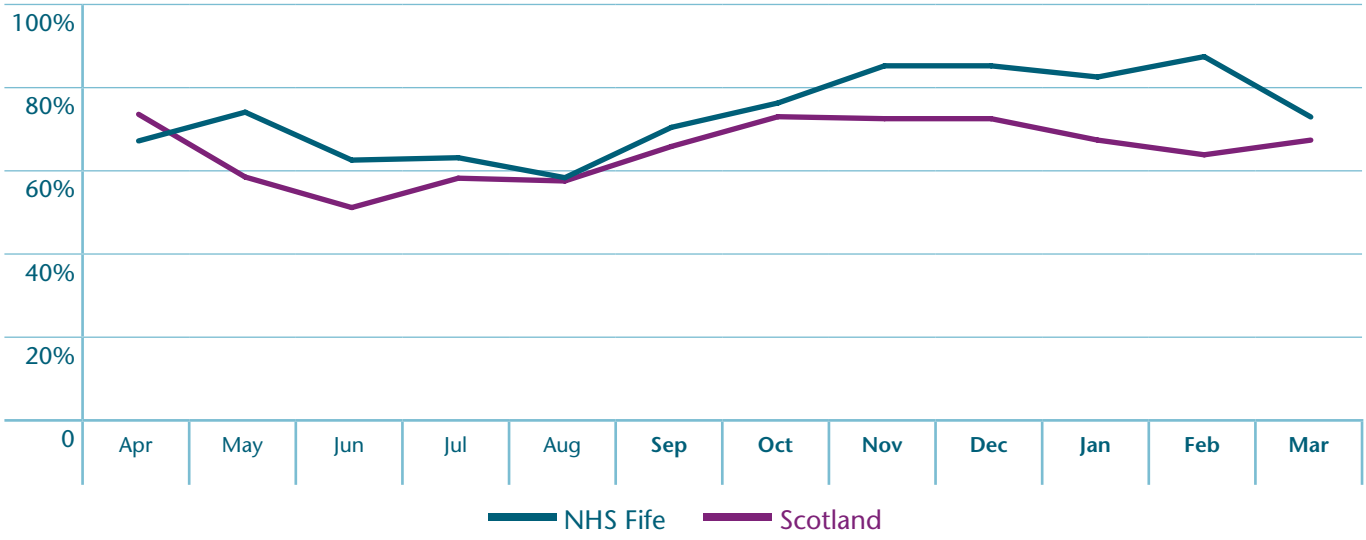
Covid-19 has had a significant impact on the mental health of children and young people across Fife. Over the past year the service has experienced a significantly higher than normal number of referrals for children and young people presenting with severe mental health difficulties and levels of risk that have required urgent intervention. This has meant that resources have needed to be moved to prioritise this group of young people which has contributed to those with significant, but less urgent needs, having to wait longer. The average waiting times for Fife CAMHS remains 11 weeks whilst those with the greatest need are routinely being seen within the same week of referral.

Waiting Times

Fife Child & Adolescent Mental Health Services (CAMHS) have successfully developed and embedded the Primary Mental Health Worker (PMHW) role into its core service provision over the past year as part of the CAMHS early Intervention Service. The allocation of permanent funding has meant that staff can be retained and the level of activity can be delivered consistently and in line with the target set for first contact appointments. PMHWs are now able to offer first contact appointments to all children referred to CAMHS via their GP within 3-4 weeks. In addition to these appointments over 50% of referrals that do not require specialist CAMHS support have been signposted to alternative service providers who are best placed to meet the child or young person's needs.

The chart shows the Local Delivery Plan Standards indicator related to CAMHS waiting times.

CAMHS 18 Weeks Referral to Treatment
At least 90% of clients wait no longer than 18 weeks from referral to treatment



Transitions

Fife CAMHS have implemented the Scottish Governments Transition Care Plan in the care packages for all young people who are requiring ongoing support from Adult Mental Health Services once they have passed the age of 18. The Transition Care Plan seeks to place the young person's views and decisions around future care at the centre of the transition process and ensures that the right people are involved to enable a smooth hand over of care.

Next Steps

- A review of the service's capacity to meet the ongoing demand has been completed in collaboration with Scottish Government Mental Health Division, Performance & Improvement Unit. The resulting action plan identifies the staffing resource required to meet the national waiting times targets and has been supported and fully funded by Fife Health & Social Care Partnership. This will result in the recruitment of 11 additional clinical staff and 8 temporary posts made permanent to ensure the sustainability of the service.
- Work with the Scottish Government's Mental Health Performance & Improvement Team will continue, to support the implementation of the additional workforce and to develop the service in line with the Scottish Government's CAMHS National Service Specification.

School Nursing

The school nurse service continued to deliver a service that is accessible, adapting to new ways of working during Covid-19 by moving to a digital platform, to ensure we could still support our children and young people and their families. This has been challenging as many young people prefer to have a consultation face-to-face. Where necessary we have utilised health centres or their homes where digital meetings would not be appropriate.

The service engaged with education colleagues to deliver parent-focused sessions on Teams to inform parents and carers how they can best access support for their young people's mental health.

The service also introduced a 'Health Zone' telephone line which is available daily for all secondary pupils to contact us if they have any health issues. The service recently undertook a survey of all our secondary schools to ascertain how we could meet their perceived needs. This had one of the highest returns for any NHS survey the data is currently being analysed to inform the next steps.

The primary 1 screening programme could not be undertaken due to school closures, however P1 questionnaire forms were distributed to parents/carers and they were invited to make contact if they had any concerns.

The 4-week timescale for children and young people who require a Looked-after Health Assessment was maintained.

Next steps

- Analyse and identify actions from the survey of secondary schools.
- Supporting recovery from the Covid-19 pandemic for all children and young people.

On Your Doorstep

www.onyourdoorstepfife.org

The Social Care (Self Directed Support) (Scotland) Act 2013 places a duty on Local Authorities to "take reasonable steps to facilitate the person's participation in the life of the community and to take active steps to promote a variety of types of support and a range of providers of support." Fife Health and Social Care Partnership's community website On Your Doorstep Fife was officially launched in February 2016 to comply with the legal duty and as a tool to improve access to local information, support and advice for supported individuals and their unpaid carers, citizens, practitioners, support workers, community groups and organisations.

Google analytics show that over the past 5 years there have been 28,000 users, 11,800 of whom logged directly into the website using the web address. There have been 138,000 page views, with mental health, dementia and befriending being the most frequently used search words. Users have logged in to the website from many cities across the UK and worldwide.

Following on from the de-commissioning of Fife Direct, On Your Doorstep has recently been moved to a new platform known as Matrix. The SDS Team, who oversee the governance, updating and publicity of the website, have been working in partnership with Fife Council's Communications Team and the Web Team to develop the website on the new platform.

A new registration/update form has been created to encourage registered organisations to update their own information. Registration requests are checked by the SDS team before being approved.

A new mental health section has recently been added to the website in response to a surge in mental health referrals and an increase in requests for support and information during lockdown. Many food insecurity initiatives and Covid-19 community response groups emerged in response to the pandemic and were added to the website to help people to identify sources of support in their local area.

During 2020 the Google map ceased functioning on the original website when a license fee was introduced by Google. This has been a barrier to those working in localities, such as staff in the Wells, who would like to be able to plot search results on a map and identify gaps in local services and supports. Work is ongoing to identify suitable, more sophisticated story mapping software. The food resilience group will pilot this first before it goes live.

Next Steps

The next steps are to continue to work in partnership with Fife Council's web team and the designer to identify a suitable map function, to explore simpler ways of editing and updating the website and to plan a fresh publicity campaign later this year to encourage more people to register community resources on the website.

Fife's Mental Health Officer Service

Fife's Mental Health Officer Team provide a service to individuals who are at risk of harm and who may need protection using statutory measures. Mental Health Officers strive to balance the need for compulsory treatment or intervention while promoting the rights and needs of people who have mental illness or who lack capacity.

Mental Health Officers work involves close working with professionals in primary and secondary care, service users, families, carers, colleagues other social work Teams, police, courts and solicitors. Mental Health Officers consider the rights-based principles which underpin these three Acts.

COVID-19 had a major impact on the MHO Team. As a result of court closures due to the current pandemic Fife Health & Social Care Partnership currently have a significant waiting list for the preparation of MHO reports for both Private and Local Authority Guardianship Orders and renewal orders. The closures resulted in an amendment to the legislation to 'stop the clock' regarding renewals with only a very small number of urgent guardianships applications being heard. As a consequence, Fife Legal Service could not progress applications for Local Authority Guardianship and renewals or complete and submit reports to accompany private applications from private solicitors 'slowed down'. This meant there was no ability to progress reports already waiting.

Since the situation started to ease earlier this year, the MHO team have received a significant number of new requests which have increased the volume of outstanding reports. The higher the number of outstanding reports, the higher the volume of correspondence, (enquiries on progress, updates in relation to risks to the person in the absence of the guardianship order which helps the manager prioritise allocation of reports), which places pressure on the MHO Duty system.

The processing of reports can only go at a pace that can be supported by the finite number of MHO's, (who also have to undertake statutory duties in respect of the Mental Health Care and Treatment Act and the Criminal Procedures Act), as well as NHS and Legal partners, and of course, the courts, (who are also dealing with a backlog of business including criminal procedures and child protection matters), so it is anticipated this issue will continue for some considerable time.

During 2020-21 we issued:

174 Emergency Detention Certificates

309 Short Term Detention Certificates

Next Steps

- To continue to work alongside partners to address the backlog of reports that have resulted from COVID-19
- To take forward improvement actions with the team aligned with the appointment of a Senior Practitioner in Performance and Improvement

Priority 3
Working with communities, partners and our workforce to effectively transform, integrate and improve our services

Delivery of effective and lasting transformation of health and social care services is central to the vision of Fife Integration Joint Board. Significant change on how services are planned and delivered with a range of stakeholders which includes carers, patients/service users who experience services is paramount to delivering changes.

Housing

A range of new Older Persons Housing has been developed across Fife, with 26 Retirement Housing Bungalows developed in Oakley, a new 30 flatted Extra Care Housing development at Napier Road, Glenrothes and work is on-going at the new care village site at Kirkland, Methil. These developments have offered a range of different living solutions for Older People in Fife.

The Affordable Housing Team are identifying potential sites for specific needs housing across Fife and joint work in the Housing Strategy Group is looking at the needs of service users known to Health & Social Care.

We have undertaken Mapping of Specific Needs Housing (Older Persons) across Fife and this has been placed on the Council's Web GIS system. This links in with our Housing Options system and allows applicants to see where Older Persons Housing is located across Fife.

Our Housing Plus project is looking to develop a range of different accommodation and support models across Fife. As part of this specifications are being developed for potential different types of service.

As part of our support to Young Care Leavers a test flat has been developed to allow Young People to test their independent living skills for a short period of time. In addition, working with Children's Services we have developed the National House Project which provides Young Care Leavers with pre-tenancy support and education. A guaranteed offer of a tenancy follows and there is on-going support after this. So far 9 Young People have been housed via this route with a new cohort of 11 Young People just starting.

Technological solutions

Through our Housing Plus Project we have been undertaking wearable technology projects across Fife. Applicants are given a smart watch, mobile phone and this is used to track their activity. We undertake "U-Check" sessions to track weight, muscle mass, grip strength etc. There is an algorithm that sits behind this and predicts the potential for a fall. Alerts are triggered which allow us to have a discussion with tenants about what they can do to prevent this.

During 2020-2021 we delivered 20 TECH solutions to service users through our pilot scheme for our wearable technology project.

Next steps

- Developing a TEC Demonstrator House – a potential location has been developed. Work is on-going to look at the type of technology that could go in the house.
- Wearable technology Project phase 2 is on-going.
- Mapping of specific needs projects is still on-going.
- Methil Care Village should be completed this financial year.

We also provided 70 tenants in Older Persons Housing with "connecting scotland" packages of I-Pads and free wifi to help with digital connectivity.

Dementia Friendly Fife

The Project was suspended between March and June 2020 due to the Covid-19 pandemic as the Manager was re-deployed to the Mobilisation Team.

Covid-19 made it very difficult to approach businesses and organisations to become dementia friendly. Many of them were closed for the best part of the year and their priority was survival not becoming dementia friendly.

A lot of activities went online and while this was a useful way to connect, for STAND (Striving Towards a New Day) members and older people living with dementia this was not accessible. This was despite the offer of technical support.

There was a dearth of space where people could meet face-to-face. This continues to be the case as organisations in the main have adopted a significantly risk-adverse approach.

Connecting with Primary Care Teams was impossible during the pandemic.

The Project Manager sourced Messages In A Bottle and distributed them to the people she is in contact with.

Once restrictions were eased in June the Project re-started. Our key achievements have been:

Working with STAND

We have undertaken work with STAND which is a group of people living with younger onset dementia and their families and friends. This has included:

- The creation of a DVD that takes the place of a face-to-face dementia friends training session and rolling this out across the Kingdom to all Dementia Friendly Fife award holders and using it to inspire other organisations to get involved in the Project.
- Supporting the organisation and delivery of the Life Changes Trust Changing Life event which was held in February 2021 – this also involved encouraging local projects to apply for regional grants – 15 organisations were successful in this and Fife secured in the region of £200,000 – the STAND group will oversee the way the grants are being used.
- Creating opportunities for activism within the STAND membership – this has involved consultation with a variety of organisations including the Scottish Government to develop the Covid Dementia Recovery Plan and the Adult Review of Social Care.

- Creating a Good Life With Dementia course. This is a 6-week course aimed at people who have been newly diagnosed with dementia. It will be delivered by STAND members and funds have been obtained from the Alliance to run this face-to-face twice in 2021 with 6 participants on each course.
- Engaging members of STAND in the Levenmouth Development Project to ensure that what is created is dementia friendly.
- Supporting SP Energy Networks to create a course about supporting their customers who are living with dementia.
- Supported STAND members to engage with an online creative writing project – this has led to the development of a proposal to create a workbook that other people can use.
- Creating and distributing the Knowledge Is Power Booklet which involved input from and liaison with the Partnership lead on our Gaelic Strategy.

Working with Older People living with Dementia

- Providing support through meeting people face-to-face, when restrictions allow, and providing support by telephone when this is not possible. Links have been made with Kinghorn Community Centre and the Toll Centre Community Hub in the High Street in Burntisland. These organisations are providing face-to-face space to meet with people when the restrictions allow.
- Exploring the Meeting Centre Model as an alternative to structured Day Care. The Project Manager has been working with a Scottish wide group of colleagues including the Life Changes Trust and Worcester University to consider this as a possible development for Fife.
- Supporting Businesses/Organisations to become Dementia Friendly. Target areas have been Burntisland and Kinghorn.
- Church of Scotland – The Project Manager gave a presentation at the Presbytery Conference in February; the focus was to inspire churches to become dementia friendly. They can do this by utilising the DVD and the One Step At A Time Guide created by Faith In Older People.
- Kincardine and Lochgelly Centres – The project Manager is on the planning group for these facilities with the aim of ensuring they are dementia friendly at the point of creation.
- Dundee and Angus College – The Project Manager is on a working group to ensure a training course they are creating for people who care for and support people living with dementia is appropriate and relevant and in particular involves people living with a diagnosis in the creation.
- The Project Manager participated in the 2-year evaluation of the Project and the distribution of it once complete.

We now have **308** organisations accredited with the Dementia Friendly Fife Award.

Next Steps

- Target the geographical areas of Kinghorn, Kirkcaldy and Levenmouth to inspire a dementia friendly community approach. Continue with the approaches in Burntisland.
- Support the delivery of 2 Good Life With Dementia courses.
- Encourage the attendees of these courses to create their own local peer support groups.
- Reconnect with schools and young people and inspire them to become dementia friendly.
- Work with the Partnership to consider the implementation of the Meeting Centre Model.
- Support the development of the Fife Dementia Strategy.
- Continue to work with external organisations to shape policy and the direction of dementia services.
- Support STAND to monitor the Life Changes Trust Regional Grants – utilise this opportunity to influence more dementia friendly areas across the Kingdom.
- Work with Police Scotland to roll out the Herbert Protocol (an information gathering tool, completed by a family member / care giver / friend / neighbour to assist the police to find a person, living with dementia who has been reported missing, as quickly as possible) and influence dementia friendly travel.

Adult Services Resources (Day Services/Respite)

Covid-19 had a major impact on the provision of Community Support Services (day services / respite) due to the lockdown and social distancing requirements. Staff adopted a flexible approach to deliver care through the pandemic, changing shifts and working with minimum staffing levels, being creative and using technology to offer alternative activities to Service Users (SUs) to ensure mental health and wellbeing was maintained e.g. Zoom exercising, walking, remote learning classes, music and movement, gardening, recycling projects. Some of our SUs have benefitted from a "slower" pace of life which has been evidenced in reduced anxieties and incidents.

Staff supported SUs to maintain contact with friends / family / carers using Zoom / Teams / Facetime / email. They also helped promote online shopping using SSCW purchasing card which also had the benefit of providing more opportunity to look for items of interest since not limited to a few local shops.

Despite the efforts of the team to continue to support SUs there was an increased number of Self Harm instances due to outreach SUs only receiving phone support as opposed to face-to-face 2 to 3 times a week. This has improved more recently, and face-to-face contact is now being increased in line with current advice.

Other challenges included:

- An Increase in hospital visits due to SU anxieties regarding Covid-19 and a knock-on effect to Mental Health and physical health.
- The impact of the forced closure of day services, resulting in SU routines being affected and increasing their anxieties.
- Not being able to support family contact has proved stressful for some SUs, their families/ Carers, and staff.
- SUs who lived in a flat, with no garden, resulting in limited contact with others and feeling isolated.

This has however provided an opportunity to appraise resources and re-evaluate how we deliver services in the future. Exploring new ways of looking at positive outcomes for the SUs we currently support.

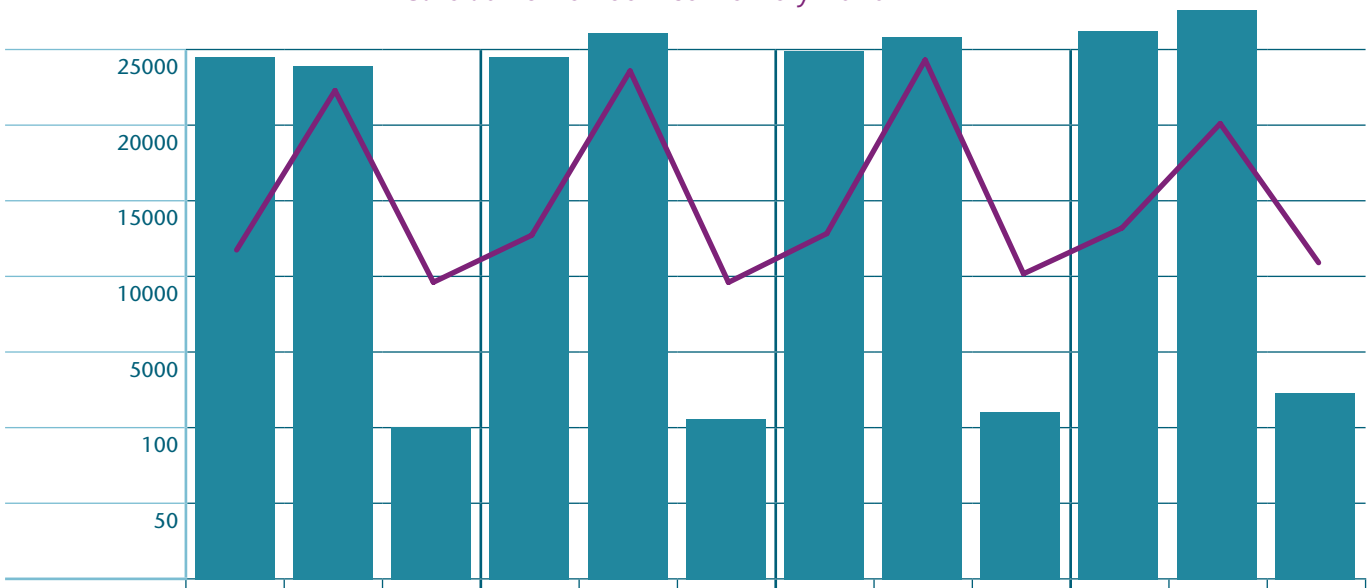
Next Steps

- Continue to use online technology for SUs wishing to purchase items that they could not necessarily buy in their local shop – creating opportunities to look elsewhere. This will involve looking at introducing cards for SUs, as opposed to staff withdrawing funds, which would be a safer option and have a trace back system which is more foolproof than cash. We will need to contact DWP to investigate getting cards as Corporate Appointees.
- Look at new ways of generating positive outcomes for SUs and re-evaluate service delivery.
- Open up visits/respite and ongoing development in line with current Government guidance. Activities will be based on guidance and Risk Assessment to ensure safe systems of work are in place and this is looked at on an individual basis, involving parents/carers in discussions.
- CSS staff having the opportunity to transfer into vacant posts in housing with care and support.

Care at Home

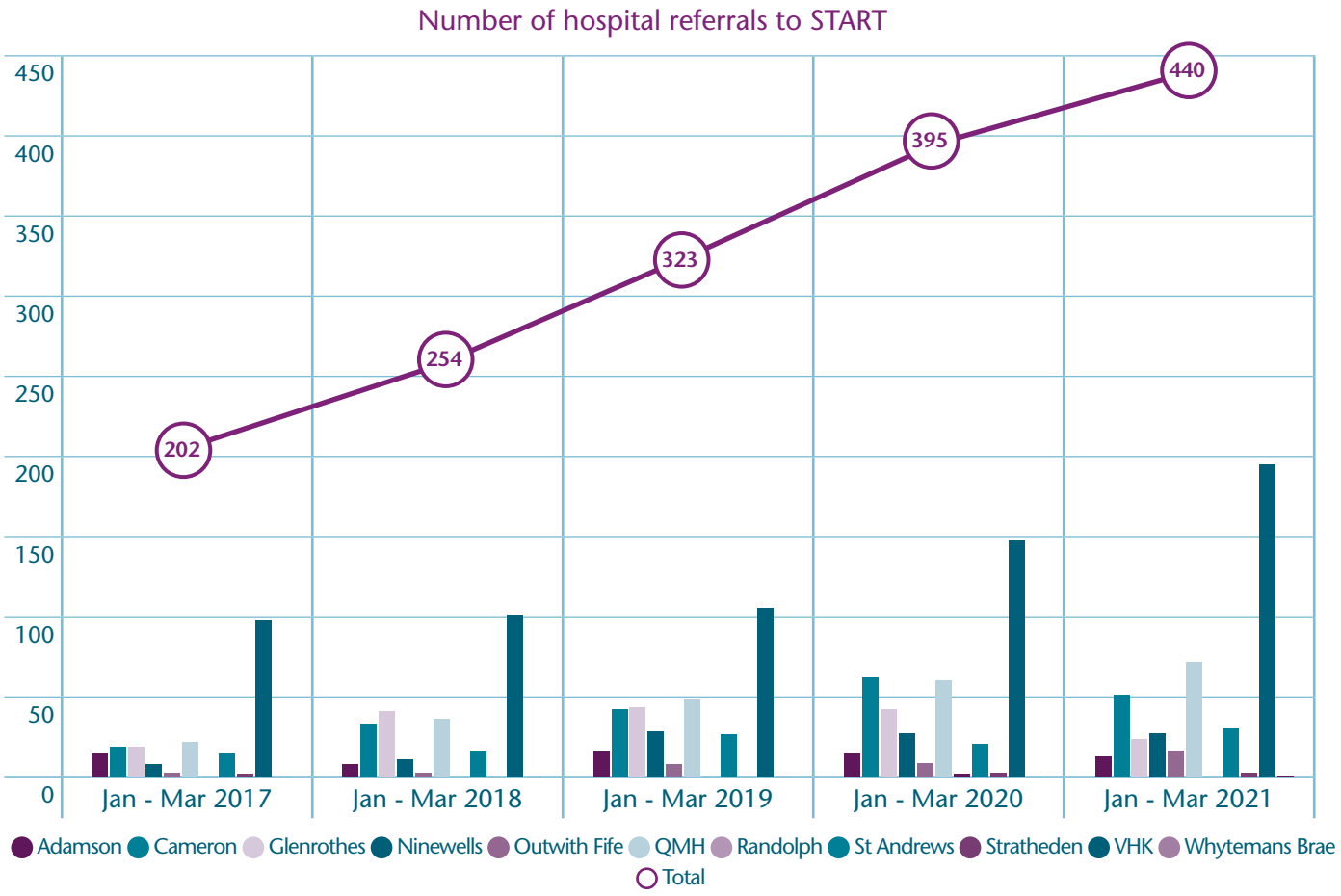
The Partnership delivers care at home services to enable people to live in their own homes for as long as possible. This is delivered through both internal care delivery Teams and purchased from independent providers. The graph below shows information on service delivery, number of SUs (grey bars including the number of SUs) and contact hours (the hours received by the SU, not including multiple workers, which is on a secondary axis and is shown as a blue line) during 2020/2021

Care at Home - Service Delivery 2020-21



	Quarter 1 2020-21			Quarter 2 2020-21			Quarter 3 2020-21			Quarter 4 2020-21		
	Internal Fife Council	Private Providers	Voluntary Providers	Internal Fife Council	Private Providers	Voluntary Providers	Internal Fife Council	Private Providers	Voluntary Providers	Internal Fife Council	Private Providers	Voluntary Providers
Service Users	1623	1597	473	1624	1697	500	1642	1685	521	1703	1768	581581
Contract Hours	117159	224197	95469	127056	237423	95384	128178	244760	101177	131879	202034	108617

START is provided by the Health & Social Care Partnership's Care at Home Service. This reactive Care at Home service is designed to support a person's discharge from hospital and significantly improves discharge planning for people with assessed needs. Residents of Fife with care needs, who wish to return home, are referred to the service from any hospital and these referrals continue to rise. The service also takes referrals for people in crisis at home and other models of care to deliver the right care, at the right time, in the right place. The chart below shows a snapshot of the Hospital referrals to START for the first quarter of each calendar year over the past 5 years.



Supporting Adults to live independently through Self-Directed Support

Fife continues to have a small dedicated Self-Directed Support (SDS) team to support colleagues in the wider service. Early on in the pandemic, Health and Social Care introduced an Additional Service Response team to support individuals and carers in our local communities. All members of the SDS team supported this work which ranged from health and wellbeing telephone calls; delivering food parcels to individuals who were unable to access supermarkets either as a result of shielding, anxiety, lack of personal resources or lack of support from family and friends; arranging the delivery of medication as well as the sourcing and delivery of PPE. Whilst this had a significant impact on the day-to-day work of the team, all staff went above and beyond to ensure that anyone who was looking for help received it or was signposted to other agencies.

As a result of the pandemic and the need to be more flexible in our approach to care and support planning, staff have been supporting operational colleagues where individuals have requested to change SDS option and/or support service, as a result of usual services being closed due to Covid-19.

During 2020, the SDS team worked closely with colleagues in Workforce Development to refresh the SDS training. The new training module focuses on the personal outcomes approach to assessment and support planning, using case studies and examples. The training also provides an opportunity for participants to reflect that their practice addresses the SDS statutory values and principles. Roll out of the training is expected in July 2021 and will be mandatory for all operational staff.

To support the refreshed training, our on-line staff portal has been revised to include useful links, accessible information, Frequently Asked Questions and our SDS animation. In addition, the SDS team has been revising and updating our Processes and Procedures all of which will provide information and support for operational colleagues.

Due to various changes in personnel, we have refreshed membership of our SDS Implementation Board. This provides an excellent opportunity to review our workstreams and to refocus on the areas where work remains outstanding. This takes into consideration the new Self-Directed Support Framework of Standards as well as continuing our developments with the recommendations of the Care Inspectorate's thematic review of self-directed support (2019) and the Self-Directed Support 2017 progress report by Audit Scotland (2017).

Covid-19 Food Initiative

In early 2021, the SDS team worked with colleagues in Communities and Neighbourhoods and Facilities on a short-term food initiative to provide dry goods and meals to individuals and families who were:

- In the shielding population or clinically at high-risk of severe illness if they were to contract Covid-19
- Experiencing food poverty
- Self-isolating and had no access to online shopping or support to obtain regular grocery supplies

Through contact with operational teams we were able to identify 49 households – a mixture of families and individuals living alone.

The SDS team contacted each family/ individual and arranged with Facilities to deliver the food parcels during the month of March. The deliveries were extremely well received:

"This helped a lot. The food I could not use or store has helped my family also, so thank you for everything you do Have an amazing day!" S&R

"The food project has made a huge difference to my family and I. Was such a help having food every week, it's a shame it had to end when it did. We were able to buy extra treats to amuse the boys…. Rather than them being stuck in the house on the computer. I would like to thank you for the deliveries the past few weeks, much appreciated – thank you and stay safe" H.S.

"The food has made a huge difference and helped me a lot during lockdown as I struggled a lot. Thank you very much" H.M.

"Thank you. This has helped me a great deal …… I didn't always have help to get out of the house ….so many thanks and I hope everyone involved stayed safe" M.E.

Towards the end of 2020, work started with Allpay as part of our implementation of prepaid cards. This will replace our current system of offering individual direct payment budgets (Option 1, SDS). A significant amount of preparatory work had been done during 2019 – this is now being refreshed in preparation for the transition to the new system. A robust communications plan has been developed to ensure each individual in receipt of a direct payment has access to advice, information and support to transition. It is anticipated this will be implemented throughout 2021/22.

We continue to work closely with our independent support organisation – SDS Options (Fife) – to ensure any information being issued by either party is consistent. We have worked closely over the year to ensure PA employers have the necessary information regarding Covid-19 arrangements, including accessing vaccines for their PAs as well as access to testing and PPE.

SDS Options
Position at 31/3/21

490 Service users in receipt of Option 1

166 Service users in receipt of Option 2

A representative from our SDS team attends the local authority SDS Network and ILF Scotland meetings. This ensures continued shared learning – which has proved invaluable during the last year.

Next Steps

- The implementation of prepaid cards will be a significant change for how we offer SDS Option 1 (direct payment) budgets however there are many benefits for both individuals whom the Partnership supports as well as Partnership staff. It will reduce the requirement for individuals to open up their own, separate bank accounts; it will remove the requirement for the submission of quarterly bank statements and evidence of expenditure; and for the service, provide a more streamlined, efficient way of monitoring how budgets are being used. It will also reduce the value of unspent funds in individual direct payment accounts, which is often difficult to recover.
- We will continue to work with partners in the voluntary sector to develop opportunities for those individuals whose services have ceased to operate as a result of the pandemic, whether as a result of reduced capacity or overall service redesign.

Connecting Scotland Project

Connecting Scotland, www.connecting.scot, is a national initiative funded by the Scottish Government which aims to reach out to 60,000 digitally excluded individuals by the end of 2021. The Self-Directed Support Team were successful in 2 separate applications for i-pads and mi-fi devices offering 24 months of free wi-fi to participants.

In the first stage of the project, 47 adults and older people were identified by social work Teams and were provided with an i-pad and free wi-fi. A further 30 adults with disabilities received their device in the second stage, 20 of whom attend Leonard Cheshire's Day Services. These adults were supported to use their i-pad to participate in online activities and to keep in touch with support staff and friends whilst their building-based service was closed during the pandemic.

Challenges of using devices

"It's too complicated. I can't use it. My brother has tried to help, but he can't do it either. My husband has been in hospital for a month, and I haven't been able to see him." (Carer aged 77)

"It hasn't been easy. My mental health officer was going to help me, but she can't visit just now due to the coronavirus."

"I'm finding it hard as I live alone. My son's friend pops in sometimes to help me, but I've forgotten it all when he goes away."

"It's not my scene at all. It has been very frustrating. I managed to send a few messages to family members but am waiting for cataract surgery so can't see very well. I don't have time to sit and learn as I'm caring for my husband who has dementia. My digital champion has been out to help me, but I don't like to bother her as she is very busy. I could really do with a step-by-step handbook to help me." (Carer aged 86)

Staff working in social work area Teams, housing and accommodation and support services, as well as support workers from care provider organisations attended online Digital Champion training facilitated by Connecting Scotland. These Digital Champions have supported 77 digitally excluded, shielding or clinically vulnerable, adults and older people to develop new skills, pursue their hobbies, explore new interests, access timely and relevant information, and connect virtually with family, friends, and support services.

The greatest challenge was ensuring speedy delivery of the i-pads to each participants, since most of the participants were in the shielding category or clinically vulnerable (as per the project criteria) which meant that staff were unable to visit them at home or to mentor them in the use of the device. This resulted in a prolonged delivery phase and participants receiving the device and instruction manual on their doorstep without the mentoring and support. We explored supporting participants electronically, but staff didn't have access to apps or devices to be able to do this. Connecting Scotland have since placed a 4-week delivery window on subsequent phases of the project.

13 people dropped out of the first phase of the project due to failing physical or mental health or admission to hospital or care home. New participants had to be identified which prolonged the delivery stage of the project. Several older adults and their unpaid carers found the experience of learning to use their device, without 1:1 mentoring or support, challenging and frustrating. Many of them decided to wait until the lifting of lockdown for support.

"My teenage son has been in hospital for some time. We used to speak on the phone, but it was hard going. For the first time, the hospital rang to say that my son wanted to speak to me on Skype. Telephone calls don't usually last long, but the skype call went on for 90 minutes. We had a great laugh together. I haven't heard him laugh like that in a long time. He can now have a chat with his brothers and sisters, his gran, and his dog online. I miss him so much. Being able to see him online has given me peace of mind and I can attend all his meetings without having to travel a distance to take part."

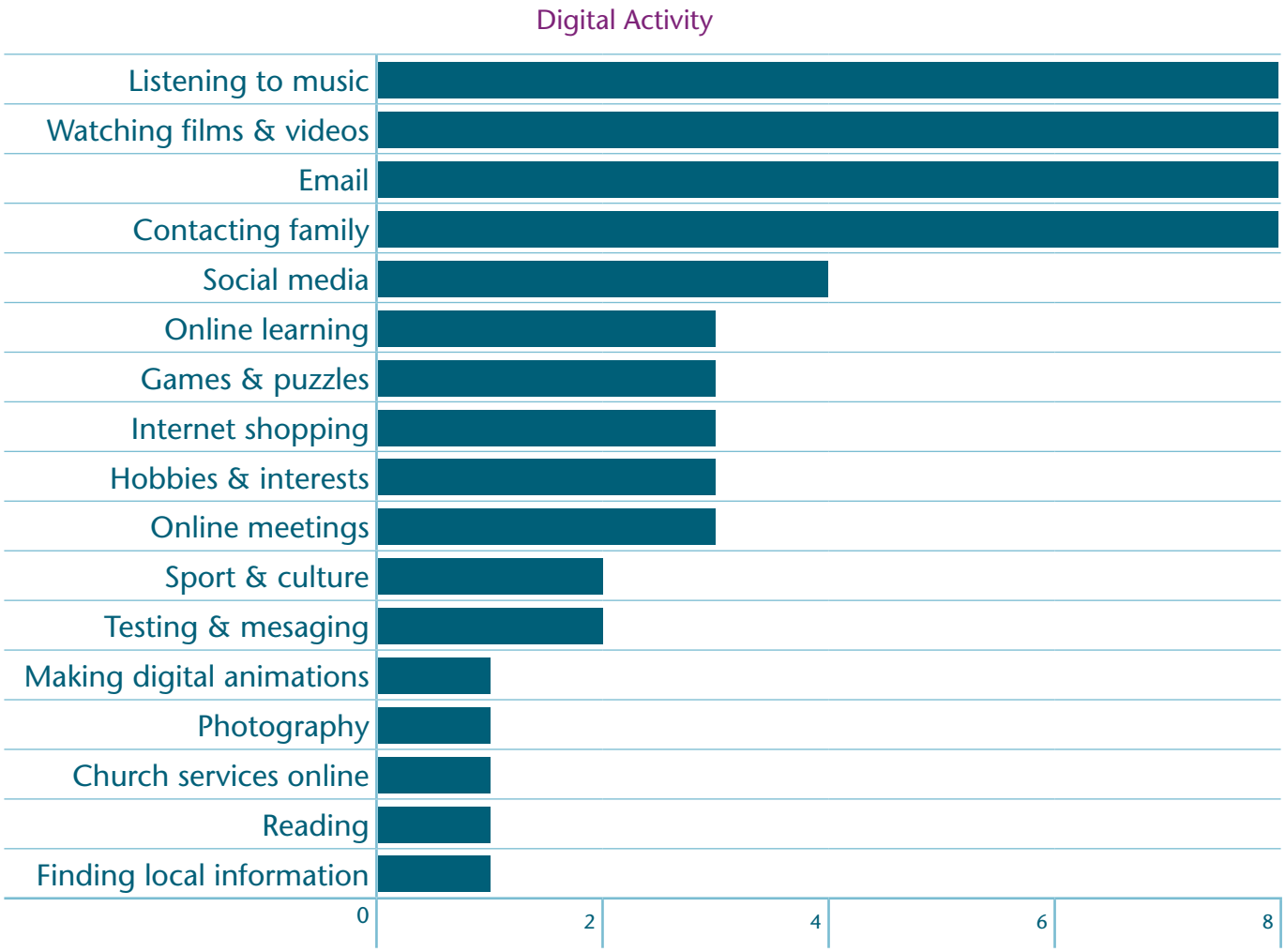
It is hoped that digital champions can visit participants who need support once lockdown is lifted, and people have been vaccinated.

Having experienced the pressures that social workers were under to deliver the devices during lockdown, it was decided that in the next phase, the Project Officer and a colleague would deliver the devices wearing PPE, whilst keeping a 2m distance on doorsteps.

This was completed within a fortnight, allowing the project officer to upload all the required project information to the Connecting Scotland database within the set timescale.

Staff from care organisations who were already supporting people at home were identified as digital champions, allowing them to mentor the participants during their allocated support time. This approach worked well and provided a much better learning experience for the participants.

30 participants from stage 1 of the project responded to the telephone evaluation and were asked what they were using their device for. The following graph shows a wide range of digital activity and the speech bubbles provide feedback quotes from some of the participants.



Next Steps

- People who have not participated in the evaluation will be contacted to find out how they are getting on with their device, the difference that being connected has made to them, and if they require support from their digital champion. Feedback will be used to prepare a final project report.
- Connecting Scotland have commissioned a research company to carry out an independent evaluation of the project. The project officer has been invited to participate on behalf of Fife Health and Social Care Partnership.
- Information has been circulated to staff who are working in employment and training or with young care leavers advising that the 3rd phase is aimed at young people and adults aged 16+ who are unemployed and seeking to further their employment opportunities.

Fife Alcohol and Drug Partnership

ADP Strategy 2020 -23

During 2020/21, the ADP devised their strategy for addressing alcohol and drug harm across Fife. This was developed using a mix of national and local policy and research analysis and a process of participation with the ADP services, stakeholders and those with lived and living experience.

The consultation process included:

- Whole system partnership focus groups
- Consultation with Current Service Providers
- Interviews with: ADP Committee Members; National Drug and Alcohol Organisations; Service users; People with lived experience; and Recovery Communities.

This provided an update of the current delivery landscape and the impact of COVID-19 on substance use, engagement, referrals, pathways into treatment and support and new modes of delivery.

From the process, five strategic key themes emerged with service-based improvement work agreed and developed under each theme. The themes are:

- Prevention and Early Intervention: Fewer people develop problem drug use
- Developing Recovery Orientated Systems of Care: People access and benefit from effective, integrated and person-centred support to achieve their recovery
- Getting it Right for Children, Young People and their Families: Children and families affected by alcohol and drug use will be safe, healthy, included and supported
- Public Health Approach in Justice: Vulnerable people are diverted from the justice system wherever possible and those in the system are fully supported
- Alcohol Framework 2018: A Scotland where less harm is caused by alcohol.

These will be monitored on a quarterly basis by the ADP Committee using their yearly delivery plan format and their risk register. Annual reports evaluating progress are produced every September and submitted to the Clinical Care Governance Group, Health & Social Care Partnership and the Scottish Government.

ADP Committee Redesign

The ADP Committee also made a commitment to improve its functionality over the next three years. This work includes the key priorities below and most of this work is underway, specifically the establishment of new subgroups to reflect strategic priorities and address the current crises in drug-and-alcohol-related deaths.

- Membership – increasing to reflect new partners including NHS Pharmacy Services
- Redevelopment of ADP Vision, Mission & Values
- New ADP subgroups to reflect priorities
- Multi-Disciplinary Drug Death Review Group - analysing suspected Drug Related Deaths in real time for service learning and improvement within ADP and in other services and directorates
- Lived Experience Panel – a strategic group to contribute to policy development and coproduce service improvements consisting entirely of people with lived and living experience of recovery from alcohol and drug use
- Outcome Performance Scrutiny Group – using a new performance outcome and delivery framework tool to measure commissioned services' strategic and operational contribution to the strategic aims and as a mechanism for directing improvement
- Addressing Alcohol Specific Death Group – applying techniques and emulating the analysis of drug related deaths to alcohol related deaths occurring in Fife. With a focus of establishing a profile of alcohol related death to improve service learning and delivery.
- Trauma Workforce Development – improving the workforce response to trauma by delivering training of evidence-based psychosocial support preparing people for psychological interventions if necessary and a means of addressing stigma within the existing ADP workforce.

Covid-19 Response

Fife ADP's response to the pandemic and subsequent lockdown was immediate and effective with the ADP and its operational Teams leading the way in maintaining support and provision to SUs whilst finding suitable ways to take referrals and keep the system of care working. Almost all services remained open in some capacity and creative ways were employed to maintain recovery communities including walking groups and supplying members with IT equipment or data. Counselling services operated a telephone or video calling service with some high-risk SUs being seen face-to-face when lockdown easements allowed. Family support and the young people's service employed social media, home visits (with PPE in place) and face-to-face meetings whenever possible. Prescription continuation and food parcels deliveries were managed within the existing workforce and mobile phones were provided to patients included early liberated ex-prisoners using additional ADP funds. Most third sector services volunteered to collect and deliver prescriptions from NHS Addiction hospital sites to pharmacies ensuring that existing patients were maintained on Opiate Replacement Therapy.

In addition, the Third Sector home-delivered (via a telephone ordering system) harm minimisation equipment including injecting equipment and take-home naloxone in partnership with the NHS BBV and Sexual Health Team. Furthermore, Take Home Naloxone kits were distributed to every NHS Addictions Service's patient, dispensed with their medication. Online recovery community cafes and support groups are examples of work to be maintained post lockdown. Especially as the latter overcame geographical barriers which predated the crisis. A summary of all the innovative and progressive work are detailed below:

- Redirection 3rd sector support to NHS Addictions/Pharmacy in distributing prescriptions to all patients as clinics were not operational
- Click/Phone and Home Delivery of Injecting Equipment provision/Take Home Naloxone
- Online Recovery Groups
- Online Cooking and/or other activities
- Changes in pharmacy supervision of OST
- Telephone Counselling
- Out of hours support
- Walking and garden Visits
- Home and doorstep visiting to most at risk families and services

The ADP held regular communication meetings with all services during the year, providing guidance offering support and improving the operational response as the pandemic and lockdown evolved. In future service planning and redesign the ADP will ensure that services retain innovative delivery and maintain their blended approach for access and engagement.

Protecting People

In 2019, there were increases in both drug related deaths up by 26% on the previous year and alcohol related deaths also rising by 18%. For drug related deaths, this is a phenomenon seen across the country and is not unique to Fife. In previous years, the ADP had used additional investment to develop new service provision for hospital liaison, employability and mentoring and expanded the existing recovery community model into new areas of Fife. However, this increase prompted a new approach and the ADP Support Team applied for additional funding twice from the Drug Death TaskForce and was successful on both occasions. This funding provided additionality in key projects below to increase capacity, reach and develop new models of service provision – particularly the Kirkcaldy next day prescribing project - to protect people at high-risk of drug and alcohol related death in Fife. This new project enables people to access ORT very quickly eliminating internal service barriers and reducing the risk of service users not accessing the service or failing to attend. This should contribute to preventing further harm to physical health, emotional wellbeing and social functioning including loss of family networks and stable accommodation. Prison peer mentoring, an expansion to community-based peer mentoring, was also developed during the year providing support to people leaving prison (a high-risk group for overdose) building relationships and wraparound service provision with those in prison and continuing care once liberated. A partnership with the violence reduction unit was also established.

Other quality improvement work funded by existing investment, further developed in the year, includes harm reduction approaches, improving access and retention to the system of care further enhancing the opportunities for people to recover. Some of the projects are listed below:

- Near-fatal Overdose Response Team responding within two days to a non-fatal overdose providing advice, harm reduction and equipment and easy active linkage into appropriate support and
- Naloxone provision expanded into: Third sector; Pharmacy Project increasing IEP, THN and Wound Care in six key community pharmacy sites where drug related harm and death is most prolific; Non-drug treatment services including Criminal Justice; and Peer Distribution
- Prison to Community Pathway
- Custody Navigation – developed over the year to respond to people
- Prison Peer Mentoring inreach and outreach
- Development of sustainable community work in areas of highest need, in particular Levenmouth
- REACH team - redevelopment of the hospital liaison element of the service provision to engage with those in A&E and key wards to improve their access to treatment and support whilst in hospital but more importantly once in their communities
- Peer-to-Peer research planned with women on access and retention in services

Joint recommissioning Support for Children, Young People and Their Families affected by substance use with Education & Children Services Directorate

In May 2020 a mapping exercise of commissioned services took place across Children's Services and all related partnerships and directorates as part of the Education and Children's Services review. During this process two Alcohol and Drug Partnership services, Barnardo's CAPSU (Children Affected by Parental Substance Use) service and Clued Up Young People's Outreach and Support service were identified due to a shared responsibility – between the ADP and Children's Services – for improving outcomes for children and young people and their families.

This process and the ADP intention to redevelop their service briefs presented a clear opportunity to strategically revise in partnership the service model, activities and outcomes required for a whole family support service working across Fife to improve wraparound support for families in need of additional and intensive support. The joint commissioning approach, intended to mitigate against siloed approaches, prevent service duplication and address gaps in service provision by ensuring the ADP's additional investment added complementary value to Education & Children's Services investment and resource. The new brief intends to provide a rapid response and early intervention approach to families working at earlier points when the family is facing difficulties. It also aims to improve the offer to young people affected by their families' substance use and/or their own use by linking whole family support into one-to-one work thus ensuring that there is sustainability and family dynamics affecting the YP are addressed as well as individual issues. Work on a one-to-one basis with YP will still be offered as part of the brief to respect the right of YP to engage with their own worker. The commissioning process was completed in the last quarter and ongoing work has involved implementation and integration of the new service provision.

Next Steps

- Specialist Social Work Service - In 2020/21, a shortlife working group was tasked by the ADP to develop a Social Work Specialist service to provide wrap-around support and case management care to service users affected by long-term alcohol and drug use and who are not currently benefitting from the existing system of care. A proposal has been written and over the next year, further work is required to realise this plan operationally within the current service delivery landscape.
- Locality Planning Project - Protecting People Levenmouth - Over a quarter of those who died during 2019 from a drug related death lived within the Levenmouth locality. The ADP Support Team has worked over the first quarter of 2021/22 to raise awareness of this issue and to ensure that this is highlighted as a priority within the HSCP Locality Board for the area. An asset based action plan is currently in development with key partners, including primary care, pharmacy, councillor services, foodbanks, Social Work, Community and Neighbourhood services, ADP third sector and locality based third sector to achieve outcomes in raising education of overdose and how to prevent it, empowering the community to assist in prevention by increasing opportunities for recovery for those at high-risk and to provide more to families, children and young people affected. This action plan will commence in year with outcomes and work reported to the HSCP Locality Board and the ADP Committee.

Working in Partnership to Support High-risk Addiction Services Patients

Addiction Services has worked collaboratively in the past year with third sector agencies and community pharmacies to support high-risk patients to prevent drug related deaths. The Covid-19 pandemic has impacted on the ability of Addiction Services to see patients face-to-face and provide care and treatment but we adopted a blended model of service delivery, utilising telephone, digital and face-to-face clinic appointments, in addition to doorstep and home visits.

Staff from third sector agencies have supported high-risk patients by visiting them at home and maintaining contact, thereby helping them remain in treatment and reducing risks.

Community Pharmacies have worked closely with Addiction Services, particularly during lockdown, facilitating naloxone provision for all opioid-dependent patients to help in reducing drug related deaths.

Fife Voluntary Action, along with third sector agencies have assisted Addiction Services to deliver prescriptions during the Covid-19 pandemic. This has ensured continuity of treatment during lockdown.

The introduction of Buvidal, a long acting Buprenorphine subcutaneous injection, administered monthly has provided patents with an additional treatment choice.

The development and commencement of a cluster review process to collectively review the care and treatment of patients who have died as a result of drug related death, has enabled the service to recognise good practice and identify service improvements.

The Covid pandemic has impacted on addiction Services by enabling the service to seek new ways of working, utilising a blend of service delivery models which is now being used to develop service, such as being able to expedite treatment for high-risk patients.

Next Steps

- The service has continued to see high-risk patients face-to-face which has proved challenging during the Covid-19 pandemic. Whilst doorstep and home visits have been undertaken and the service has received support from third sector agencies, this has been resource-intensive and the need for a mobile facility for rural areas has become apparent in order to engage, treat and retain high-risk individuals in treatment in order to reduce drug-related deaths.
- In the next year the service hopes to prioritise Opioid Substitution Treatment, ideally on the day of first presentation, in line with the Medication Assisted Treatment Standards from the Drug Death Task Force. Work has commenced to develop and implement a service that will enable people to commence treatment on the first day they present and are assessed, if clinically safe to do so.

Transferring Immunisation Programme

The centralised immunisation team went through an accelerated programme of change between 2020-21.

- All childhood vaccination programmes transferred to the central team by April 2020
- The planned move of the 0-5 years programme from general practice into community venues had to be rapidly deployed due to the pandemic and the resultant physical distancing restrictions. This involved moving from the automatic invitation / fixed appointment method to a more personalised service user engagement via telephone with choice of appointment date and time.
- In May 2020, on the anniversary of the first modern smallpox vaccine, the service realised a permanent base for the team when they moved into the Edward Jenner Suite, named after the man who pioneered the very concept of vaccination.
- In May 2020, the team began working with two retired GPs to support delivery of the 6-8-week new-born baby assessment alongside our immunisation clinics. When the pandemic hit, this service (part of general practice delivery) was halted and by April it was noted that the number of babies missing this essential assessment was growing and would continue to do so. The team quickly supported a new delivery process and this continued until August 2020, by which time practices were equipped and ready to resume this service.
- The team was then approached by the audiology department with a similar issue; hearing assessments for babies, usually delivered within the acute hospital setting had been halted. The team altered practice and delivery once more to support the inclusion of this service; a 'One Stop Shop' approach for new-borns was implemented. Health Visiting and Family Nurse Partnership colleagues supported dissemination of information to new parents. A truly collaborative approach provided the best care for our youngest population with the resultant activity contributing to performance indicators across several services, as 674 babies accessed this one stop shop over a three-month period.

- Part of service delivery change in 2020 was also the increase in home visits for vaccination; prior to this home visits were only delivered in exceptional circumstances. The pandemic saw a rise in the need for this activity, with new barriers to attendance highlighted across many cohorts. The team adapted by providing vaccination in the home, where assessment deemed it the most appropriate route. With restrictions lifting, the need for this service has reduced but a scaled down response will be embedded as routine practice to support the needs of the Fife population.
- Transfer of the 2-5-year pre-school flu vaccination programme was planned for 2020, however the expected delivery model had to be altered to provide vaccination in community-based clinics. This was a difficult program to execute and required increased focus on alternate engagement methods than those previously identified.
- Primary school flu also proved challenging. The traditional model of delivering from a main school hall, where children are brought for vaccination class by class, was untenable due to social distancing measures. The team adapted by either putting the vaccinator into the classroom or delivering from a mobile unit (hired from Fife Libraries). Although onerous and a further stretch of capacity, this model was well received by our education colleagues and parents and guardians of primary school pupils. Both the pre-school and primary school flu programmes resulted in the highest uptake Fife has achieved at 59% and 76% respectively.
- Further challenges of delivering seasonal flu vaccinations led to another accelerated program of delivery for the team; the expectation for the 2020 adult flu vaccination campaign was the piloting of vaccination delivery to residents within care homes by the centralised immunisation team. The pandemic increased the requirement to move this activity away from general practice at pace and the team delivered all flu vaccination to residents and staff across both Residential Care and Nursing Care Homes. Support to deliver flu vaccine to the general adult programme, saw the team deliver targeted 'pop-up/drop-in' flu clinics within areas of high socioeconomic deprivation, and provide vaccination to a large number of the housebound cohort across Fife.
- Provision of delivery of the Covid-19 vaccination programme across care and nursing homes soon followed flu delivery. By December the team had commenced vaccination of first dose Covid-19 vaccine to residents and staff and completed the two-dose programme by March 2021.
- The team continue to support the Covid-19 vaccination programme by delivering a long stay and inpatient service for hospitalised patients. A high-risk clinic was also established and continues to be delivered by the team for individuals who require vaccination in a setting with immediate access to life saving equipment.

Next Steps

- Identify funding to increase the staffing complement within the team in order that we can increase our deliverables and thus improve uptake levels, whilst also improving the leadership structure of the team to allow for a better spread and oversight of the service.
- Support senior staff to access training as non-medical prescribers, this will allow for the dependency on GPs to provide prescription for non-routine vaccines to cease.
- Review all community clinics and agree long-term lets in venues that are appropriately equipped, accessible, and within the best setting for our population.
- Identify funding for the permanent use of a mobile unit to support engagement with our most disadvantaged populations.
- Obtain a decision on where the final transformation of the routine adult vaccination programme and the travel health programme should be delivered. If this is to be managed within the centralised immunisation team an appropriate resource requires to be identified and funded. This also applies to any parts of the adult flu or Covid-19 programmes devolved to the team.
- Implement digital solutions to reduce administrative-heavy tasks and provide safer and more effective management of individuals through our service.
- Develop outreach and education programs to improve understanding of immunisations and dispel myths and rumours, together with the provision of information workshops for parents of children transferring from nursery to school and for parents of children transferring from primary to secondary school. The first pilot workshop is planned for early 2022.
- Long-term developments include improvement of our social media presence and to transform our web page to be more interactive for the service user. We'd like to move to a six-day, 8am-8pm service, providing increased opportunity for vaccination outwith standard working hours and provide a self-booking appointment system to support this. We'd also like to provide a dedicated phoneline and call centre to support enquiries from our service users.
- The long-term vision is for a gold standard vaccination service delivering to the population of Fife, which is aligned to the professional nursing structures and is included within the nursing career pathways. A service with quality and safety at its centre, providing positive experiences in vaccination, ensuring that whether vaccinating a new-born infant or an elderly person, our staff have the knowledge and expertise required to support the individual needs of our patients.

Community Nursing Services

Transforming Community Nursing

An enhanced Community Nursing workforce is key to ensuring people can be cared for at home or in a homely setting, reducing avoidable admissions to acute hospitals, and enhancing 24/7 provision in primary care.

The Community Nursing Service has been central to the delivery of essential and urgent care during Covid-19 and will continue to be so during recovery. Targeted investment to grow this workforce will therefore support services across Scotland. In line with national and local strategy, we aim to build capacity and capability, optimising our community nursing workforce to ensure we have the right people with the right skills in the right place to deliver high quality, person-centred, values-based care.

The Covid-19 pandemic has been challenging for the community nursing Teams in that it has stretched them out with their comfort zone and much of their work had to be delivered in a very different way.

At the start of the Covid-19 pandemic, the community nursing Teams had to adapt to new ways of working to deliver an adapted model of care delivery in line with national guidance. In Fife, the Teams had already integrated in many ways with other community Teams such as Intermediate Care and Assessment Support Services (ICASS) and Intermediate Care Team (ICT) however in response to demand, the community nursing Teams worked with Hospital at Home (H@H), Fife Specialist Palliative Care, Marie Curie and Urgent Care Services Fife (UCSF) to deliver a collaborative approach to community care delivery.

In the last year NHS Fife have reviewed service delivery in the evening and overnight period and the team is now managed by one team leader and is covered by a waking night service and on call staff. In the first instance this was in response to COVID-19, however is now an integral part of the Community Nursing Service.

Teams worked cohesively, co-locating the Evening Nursing Service (ENS) with Urgent Care Services Fife (UCSF) at Victoria Hospital in Kirkcaldy and Queen Margaret Hospital in Dunfermline. They also enhanced and embedded multi agency safety huddles so that daily communication was improved between services creating a more joined up and integrated approach to community care delivery.

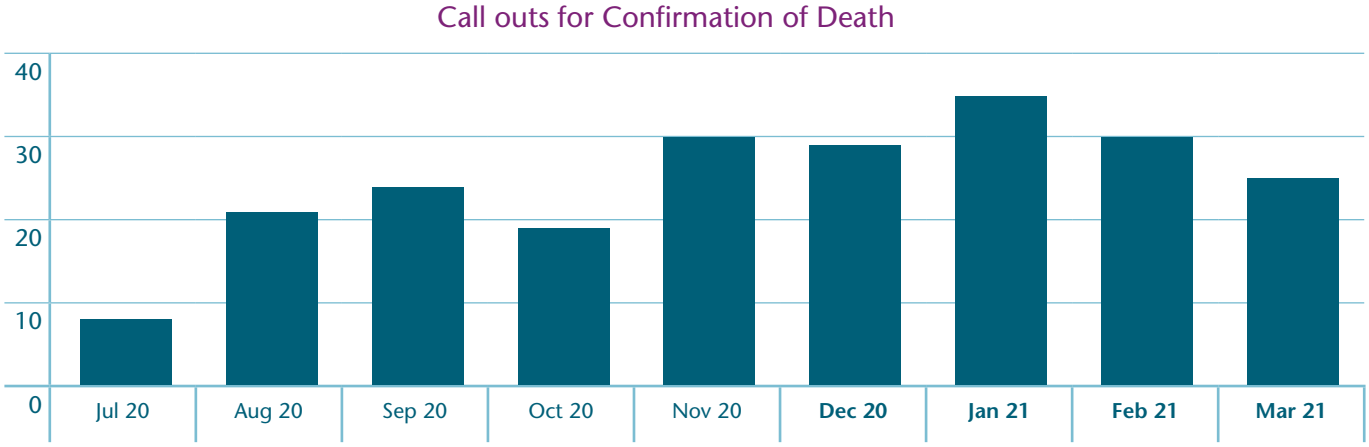
During the pandemic many community nurses were undergoing Masters Level education with 14 nurses in training as District Charge Nurses (DCN) on the PgDip District Nursing and 6 undergoing the PgDip Integrated Community Nursing. This ongoing programme of education and training is in line with the transformation of community nursing agenda and is a key priority to future proof the service, building capacity, capability and sustainability to enable a workforce which is fit for the future.

Next steps

- Progress the community nursing transformation agenda in Fife, including additional training posts and career progression pathways. Work is already underway to recruit to additional posts in Year 1 of this programme.
- Undertake workforce tools
- Adapt acuity and dependency scales as appropriate for Hospital at Home

Maximise the contribution for the nursing workforce.

During the COVID-19 pandemic, community nursing commenced confirming deaths of known patients and ensured seamless patient care at end of life. This commenced in July 2020, and up to the end of March 2021 a total of 221 call outs / confirmation of deaths was recorded across East and West Community Nursing Teams.



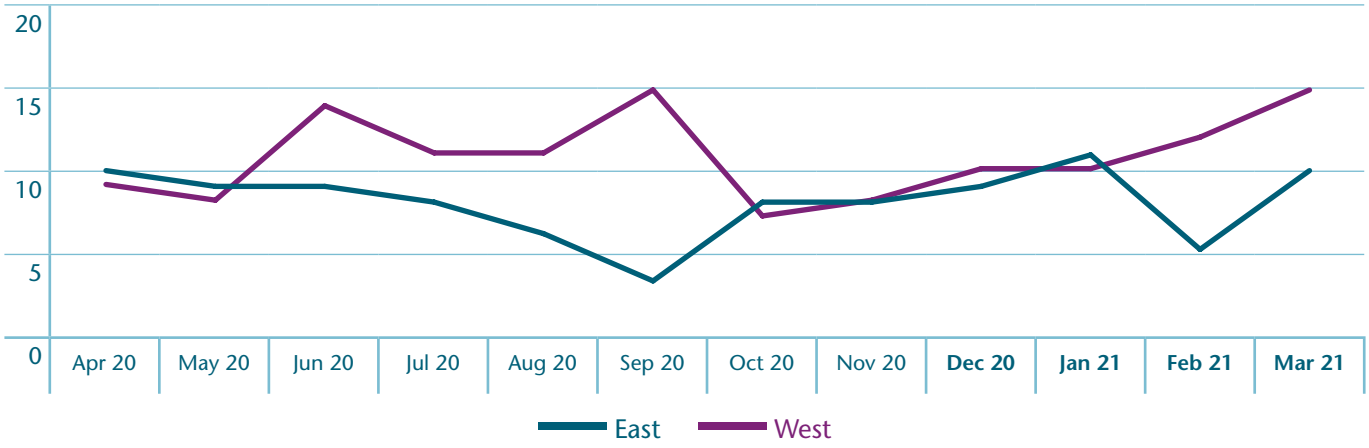
Continuous quality improvement in the reduction of caseload acquired pressure ulcers.

In terms of quality outcomes, the service has been challenged with increased tissue viability incidents within community nursing. Causes may be multi factorial mainly due to constraints placed upon service delivery during the COVID-19 pandemic and inability to maintain normal surveillance. Thankfully normal business has resumed now for the Teams and the service will aim to see marked reduction in tissue viability incidents in the coming year.

Joint working with care homes in relation to tissue viability: during the pandemic it became apparent very quickly that there was demand from care homes to reduce their footfall. To overcome this, new processes were developed whereby nursing homes would make a referral with photographic details of the pressure ulcer. A return response is made by Tissue Viability Nurse (TVN) with either a wound management plan or a home visit.

Training and education continued to be delivered during the pandemic via MS Teams and included Wound Management products in line with NHS Fife Formulary.

Total Number of Monthly Presure Ulcers 2020/21
East & West Localities



Continue to inspire public confidence in care during times of significant service transformation.

The Community Nursing Service has previously used the approved PePPERS (Personalisation, Participation and Responsiveness in Healthcare questionnaire) model for capturing patient feedback. However, due to the Covid-19 pandemic this was not repeated during 2020-2021. It is hoped to return to this in 2021-2022.

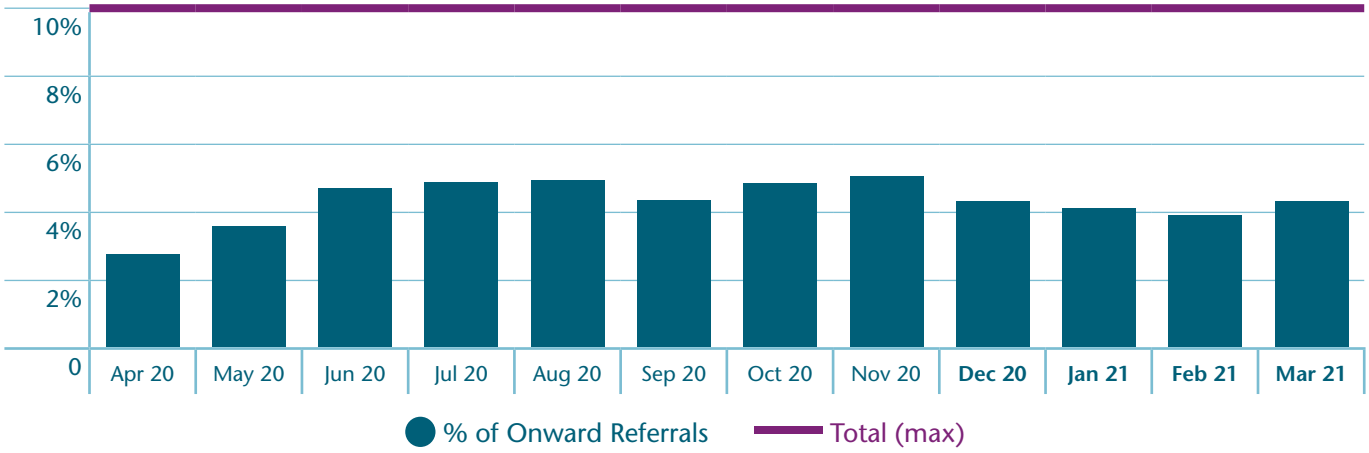
Community Dermatology Specialist Nurse service: due to reduced capacity within hospital based dermatology, referrals to the community Dermatology Specialist Nurse service increased. The specialist nurse is now seeing approximately 100 patients per week. During the Covid-19 pandemic approximately 50% of consultations were virtual (e.g. NearMe, telephone consultations), however due to the nature of dermatology face-to-face consultations are preferred in terms of skin assessment. The Dermatology Nurse Practitioner has reverted back to nearly all consultations being face-to-face.

Urgent Care Service Fife

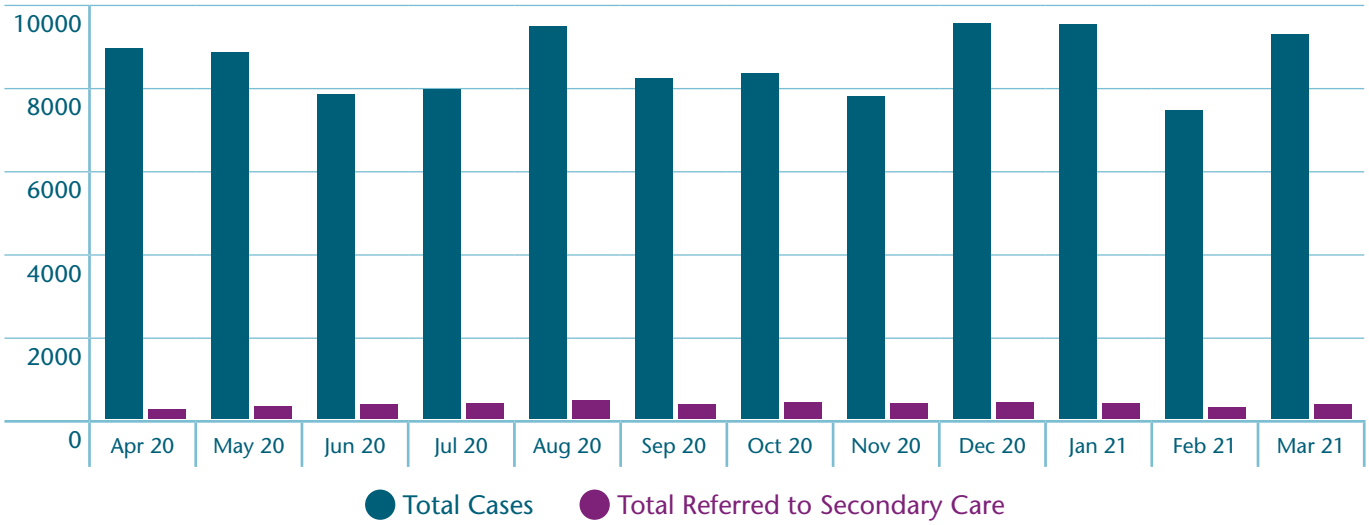
Improve help and support for people who need a clinician:

- Onward referrals to secondary care: The Urgent Care Service Fife aim to refer no more than 10% of their presentations for further assessment within secondary care. Between April 2020 and March 2021 Urgent Care Services Fife continued to achieve the target of less than 10% onward referrals to secondary care, resulting between 95.05% and 97.26% of all patient contacts managed within the service

Percentage of Onward Referrals



Urgent Care Services Fife: Onward Referral to Secondary Care
Number of Patient Consultations



- Out-of-time visits: At least 90% of Urgent Care Service Fife (UCSF) patients will wait no longer than their specified time stratification based in relation to the clinical need. Between April 2020-March 2021 UCSF, like many services, had to cope with reduced levels of staff (Covid-19 isolations etc), peak activity times e.g. public holidays including Christmas and New Year, and winter weather / disruptive travel. All out-of-time visits are clinically reviewed. In early 2021, the service implemented a test of change whereby introducing additional dedicated local clinical review of all home visit end point contacts generated from NHS24. This local clinical review allowed for patients to be managed in a timely manner, allowing for telephone advice / signposting and allowing more efficient use of resources resulting in fewer out-of-time home visits compared to the same period the previous year.
- Urgent Care Services played a key role in supporting Fife's response to the Covid-19 pandemic, with the mobilisation of the Covid-19 Assessment Centre, which has now seen approximately 20,000 contacts since March 2020.

- Improved transport support for patients. Patients who require access to the Urgent Care services in the out of hours period are offered the opportunity for transport support. This ensures fair and equitable service delivery for patients, families, and carers. Patient transport was also extended to patients requiring to be seen at the Covid-19 Assessment Centre during the in-hours period.
- Expanded use of virtual modes of clinical assessment in the out of hours period with increased use of Near Me and telephone triage / advice.
- Flexible multidisciplinary service delivery model for out of hours urgent care across Fife, including face-to-face clinic / virtual appointments; telephone advice, home visits, minor injury.

Support general practitioners and their Teams

- During the Covid-19 pandemic, the Covid-19 Assessment Centre provided a safe, clinical space for symptomatic patients to be seen, thus reducing the burden and risks place on General Practice.
- Urgent Care Service Fife provide a professional-to-professional advice / referral telephone line for General Practice and other partners including, amongst others, District Nursing, Scottish Ambulance Service and Care Homes.

Urgent Care Redesign/ Transforming Urgent Care

Urgent Care Services Fife (UCSF) has undergone significant change and transformation over the last year. The strategic vision for the Urgent Care Transformation and Redesign work is to support the public to access the right care, at the right place, at the right time, first time. Traditionally, UCSF operated 118 hours per week as an Out-of-Hours service from the Maternity Unit at Victoria Hospital however in March 2020, was tasked directly to support Fife's Covid-19 pandemic response, hosting the Covid-19 Assessment Centre at the Diabetic Centre in the grounds of Victoria Hospital and Remote Telephone Triage Centre at Glenrothes Hospital. Workforce resource was deployed from the GMS Community ANPs and GPs in Primary Care to ensure the patient had clinical review and sign-posted to the right place. All national urgent care activity was directed through a Single Point of Access (SPOA) at NHS24 via 111 and then reviewed locally in Fife by suitably trained clinicians at the Telephone Triage Centre. Many referral pathways were created to improve access to virtual triage and face-to-face assessment from Care Homes, Paediatrics, Maternity, Palliative Care, Hospital at Home, Mental Health Teams, SAS, Community Nursing and ED and acute care admissions pathways. The impact was that UCSF were supporting greater levels of activity and delivering a 24/7 model of urgent care delivery.

Clinical safety was number one priority and processes and protocols were rapidly developed to support safe transition of care from an out-of-hours service to a 24/7 model. Performance indicators were closely monitored with constant review and evaluation of activity and patient safety data. During the Covid-19 pandemic, activity was better controlled due to the SPOA and scheduling and reduction in unscheduled attendances.

The senior clinical team enabled the workforce, facilitating knowledge of clinical pathways and appropriate training in place. Staff were given the opportunity to learn and develop new skills such as NHS Near Me to support virtual triage and new ways of working and worked collaboratively with other services to deliver high quality, safe and effective care.

In August 2020, NHS Fife was given a directive to implement a Flow and Navigation Centre (FNC), one of 5 workstreams underpinning the Urgent Care Redesign Programme in Fife. On 1st December 2020, the FNC was launched with success and is currently completing on Phase 1 of the programme developing seamless clinical referral pathways to the ED and is now progressing towards Phase 2 which includes referral for acute admissions and paediatric pathways.

Over the last year, the UCSF nursing workforce has developed significantly to include new roles such as the Clinical Coordinator and Team Leader. During the pandemic, many nurses were already being supported through Masters-Level education and training which has continued throughout the pandemic with many of these skills requiring advanced decision making. The entire nursing team have developed enhanced skills in virtual assessment and telephone triage skills including the use of Near Me with some continuing university education to complete Minor Illness, Minor Injury, Advanced Patient Assessment and Clinical Decision Making and Non-Medical Prescribing qualifications concurrently.

Next steps

- Continue to progress in line with the Urgent Care Redesign Programme locally in Fife and Phase 2 national Urgent Care Redesign priorities as directed by Scottish Government.
- The multidisciplinary Teams shall continue to develop, building capacity, capability and resilience within our workforce to deliver on future priorities ensuring that staffs have the right skills and knowledge to perform safely and effectively.
- Continue to engage with staff and the population of Fife around Urgent Care Services.
- Continue to provide leadership to the Redesign of Urgent Care Programme, in particular Fife's Flow and Navigation Hub.

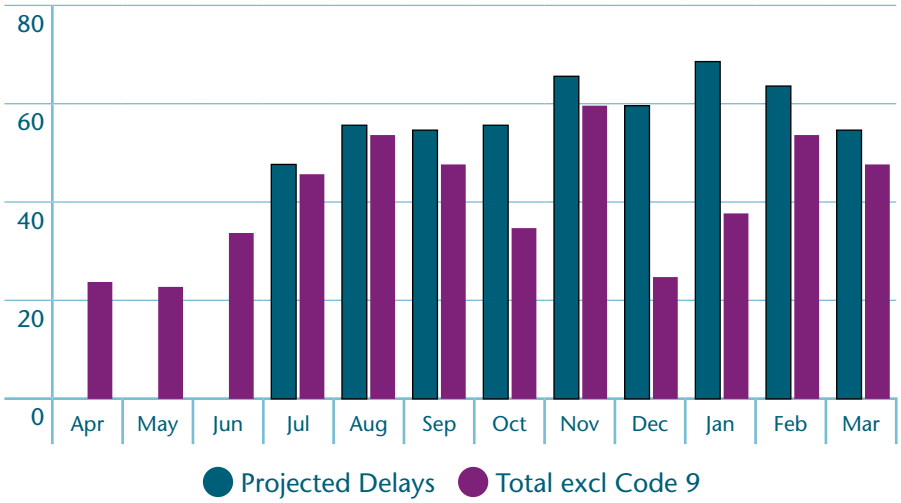
Continue to deliver the Transforming Urgent Care Programme through creating a sustainable model within QMH out of hours for both minor injuries and urgent care out of hours activity.

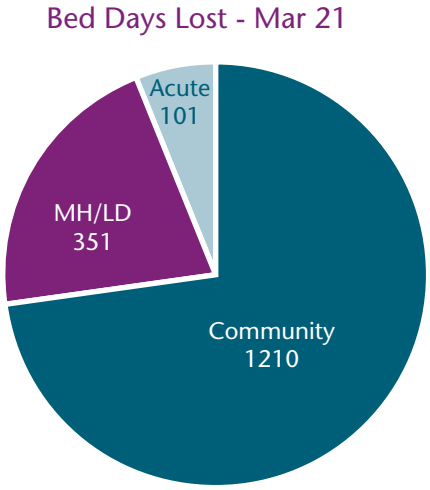
Integrated Discharge Hub & Community Patient Flow

Improve patient experience and reduce delays in transfers of care

Aim to reduce the number of people who are delayed in hospital for 2 weeks or more by 20%

The graphs below show our performance against our indicator "We will reduce the hospital bed days lost due to patients in delay, excluding Code 9, to 5% of the overall beds occupied"



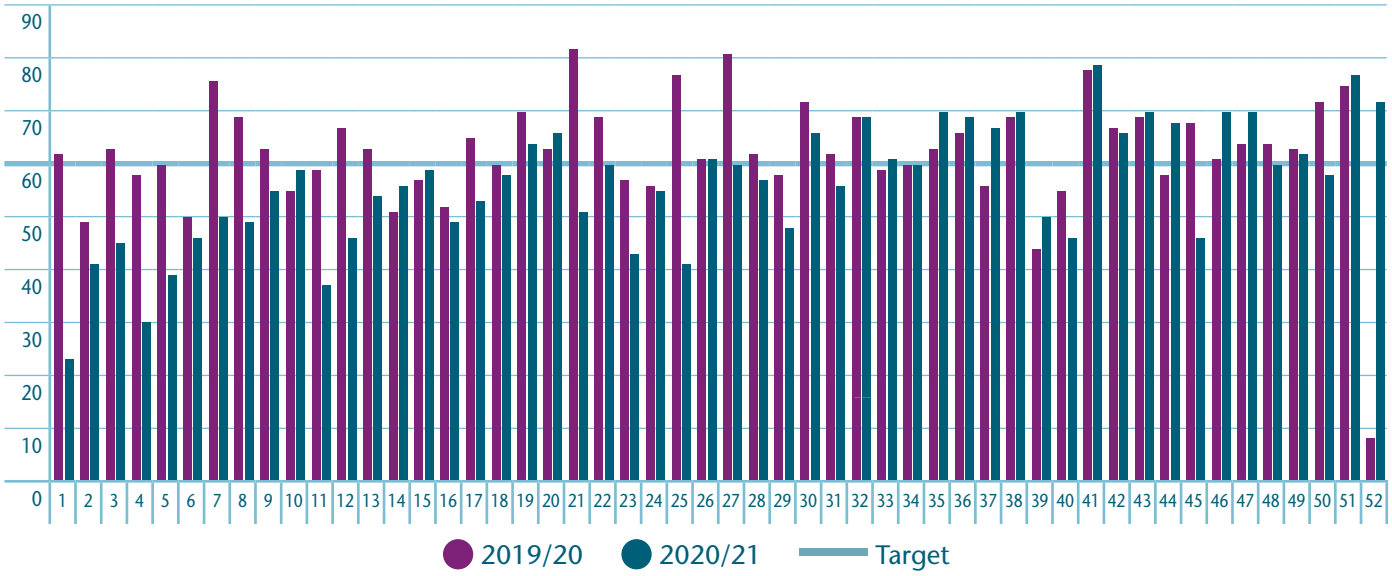


Aim for 60 people or more discharged into health & social care resources per week from the VHK HUB

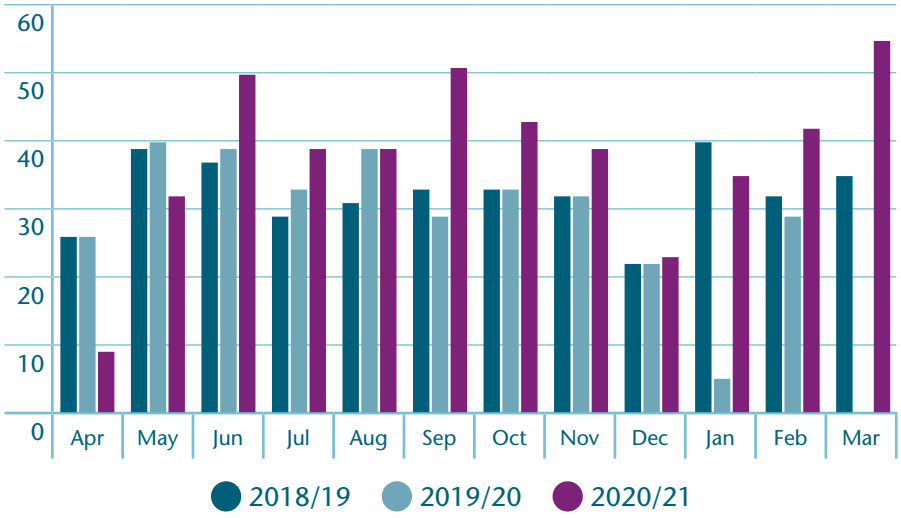
Within Fife there is a whole system approach to reducing delayed discharges. The past couple of years has seen a reduction in the number of days individuals spend in hospital after they have been deemed ready for discharge. This can be attributed to several initiatives including redesign of home care services, better links with the acute hospital and H&SCP through the multi-agency Discharge Hub, and collaborative working with the third sector including earlier direct support for carers, veterans, and homeless individuals.

- Carer Support Services:
- To improve the support carers receive at discharge;
- The aim is to increase the number of people receiving support within the Acute and Community Hospitals. Total referrals for April 2020 – March 2021 was 39.8% higher than the same period the previous year.

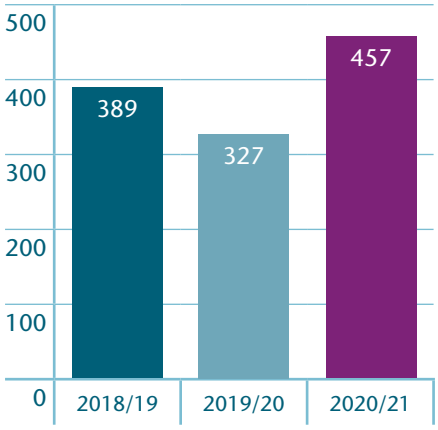
Total Weekly Discharge from the HUB



Number of Monthly Referrals for Carers Support



Total Number of Yearly Referrals for Carers Support



Home First

Establishment of Home First Oversight Group to provide leadership and direction of the delivery of an integrated Home First strategy across Fife.

The Home First strategy within the acute and community hospitals in Fife aims to support the strategic direction of the Fife H&SCP to redesign care to ensure people have the opportunity to be treated at home or in a homely setting. People who are ready for discharge and do not require a hospital bed may still require short term health and social care services. Where it is safe and appropriate to do so, this can be provided in their own home or another community setting in an approach known as Home First.

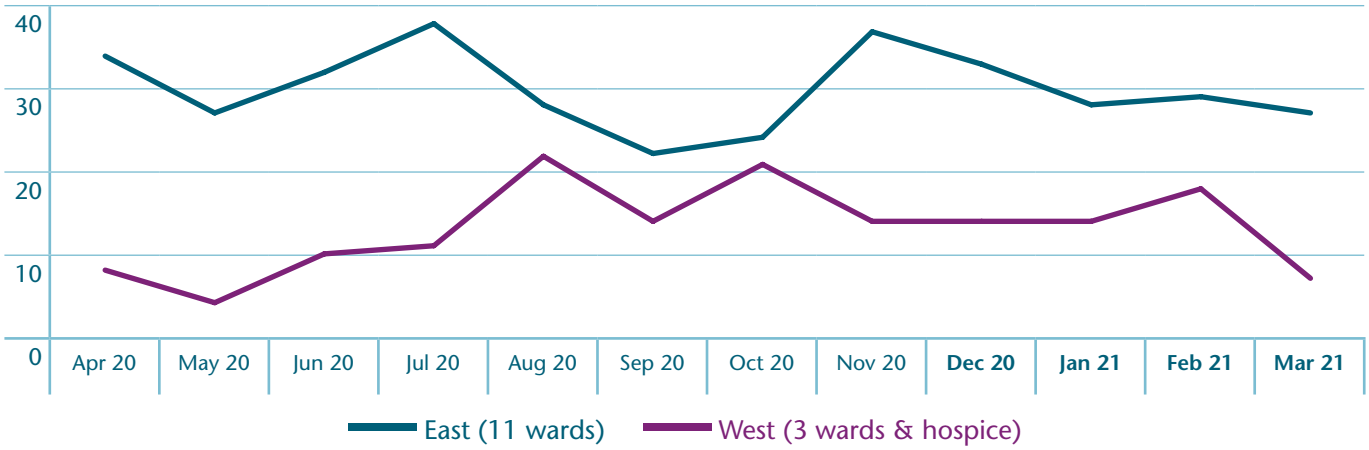
Personal outcomes and whole system approaches allow for community alternatives to hospital admission to be explored and include frailty screening to prompt early specialist geriatric assessment. Active participation by patients and their carers / families ensures understanding and contribution, as appropriate, to care delivery and discharge planning, including the use and sharing of anticipatory care plans. Patients are identified a 'named person' who has responsibility for coordinating all stages of discharge planning throughout the patient journey.

- Inpatient Nursing
- There has been targeted approach to reduce falls in all community hospitals across Fife. For the months that there have been peaks, the SCN, CSM and HoN analyse the data and agree interventions.

Inpatient Nursing (East)

Medicine of the Elderly Rehabilitation is based across four community hospitals in the North East of Fife and provides a multi-professional approach to rehabilitation and re-enablement with expertise in managing more acutely unwell patients and complex discharge planning. The patient group is predominantly frail elderly; however, there are a growing number of under 65s with complex health needs admitted to our wards. There is also a Consultant-led neuro-rehabilitation service.

Number of Monthly Falls (all wards)



These four community hospitals comprise 182 inpatient beds and this includes:

- Hospital Based Complex Clinical Care
- Rehabilitation for frail people (including those with cognitive frailty)
- Neurological rehabilitation
- Stroke Rehabilitation
- Palliative care
- OPD
- MIU

The ME/CFS (Chronic Fatigue) service in NHS Fife has been nurse-led since 2004 and is the country's longest running nurse-led service for the condition. Before Covid-19 the prevalence of ME/CFS was 1 in 200. Since September 2020 a third of all new referrals to the ME/CFS clinic are from post viral illnesses, suspected Long Covid-19 or confirmed from test prior to referral.

Next Steps

- New models of care: such as Home First.
- Moving On policy ensuring discussions are commenced on admission.
- Neuro rehabilitation: redesign and alignment of services within 18 months.

Inpatient Nursing (West)

Medicine of the Elderly Rehabilitation is based at Queen Margaret Hospital and provides a multi-professional approach to rehabilitation and re-enablement with expertise in managing more acutely unwell patients and complex discharge planning. The patient group is predominantly frail elderly; however, there are a growing number of under 65s with complex health needs admitted to our wards.

In Queen Margaret this service comprises:

- 80 beds
- Three inpatient wards (currently 4 due to pandemic and infection control measures regarding bed spacing)

Next Steps

- New models of care transfer.
- Test of change for Stroke (anticipated Oct 2021).

GP Fellows

The GP Fellows initiative was created to address the need to recruit and retain GPs in Fife. The posts were set up as temporary three-year positions (commencing 2018) with the first year focusing on training and development in clinical, quality improvement and project management skills. Following the first year, the emphasis moved to a combination of GP work and contribution to service development.

The posts were developed to be attractive to GPs who do not wish to be in Partnerships in Practices at this stage of their career and allow them to maintain a mainly clinical role. The opportunity to be involved in developing and shaping community services was also intended to attract GPs to the posts.

It has been recognised that a huge value in the GP Fellows' frailty clinic is the ability to address the needs of people with multiple conditions and the multiple effects on an individual from each condition. As well as having adequate time in the clinic (compared to the time available from a GP), the GP Fellows' location in the Hub allows for rapid multidisciplinary assessment when required and this provides the opportunity for comprehensive and early intervention.

The GP Fellows' contribution is illustrated in two examples:

- Coordinated working with old-age psychiatry led to an urgently referred patient with significant weight loss being assessed medically and cleared of physical causes. This led to a more rapid conclusion that dementia and depression were the key contributory factors.
- A patient with sudden decline was urgently assessed by GP Fellows and MDT. Medical investigations and management were rapidly undertaken, and therapies commenced. As a result, the patient's condition, independence, and quality of life improved significantly.

The comprehensive assessment and coordination with Hub services probably prevented further decline and possible hospitalisation in the two people outlined above. They are not unusual, and these situations are very representative of the increasing numbers of frail and older people with more than one condition.

Next Steps

- To develop a GP Fellow Fife-wide team.
- To have integrated Fife-wide Frailty Service incorporating the GP Fellows, Day Hospital, Hospital@Home and ICASS

ICASS / Intermediate Care Teams / Community Occupational Therapy

Intermediate Care Team

Intermediate Care Teams cover a range of integrated services to provide rehabilitation to promote faster recovery from illness, prevent unnecessary hospital admission, support early discharge, and maximise health and wellbeing. Intermediate Care is provided directly by a multi-disciplinary rehabilitation team comprising of physiotherapists, occupational therapists, nurses, social care staff (Rehab Support Workers and Home Care Managers) and non-registered Health Rehab Support workers. Alongside this team we have Community Occupational Therapists and Social workers who attend weekly virtual ward rounds.

The skill mix provided within the ICT ensures that there is a wide range of knowledge and skills from our junior staff through to our specialist therapists. Areas of specialist knowledge and expertise within the Teams across Fife include Neuro Rehab, Pulmonary Rehab, Vascular and Stroke, Parkinson's, Dementia, Orthopaedics and Falls and Frailty Management. The management of patients with multiple pathologies and complex care needs is also an area of expertise which involves particular knowledge of equipment and environmental needs and understanding of resources across the local communities.

The team will plan, in collaboration with the patient, carers and relevant others, a programme enabling people to achieve an appropriate level of independence in everyday tasks, self-manage health issues and support any short and long term personal outcomes. The duration of the service will vary according to the individual need, but may be for up to six weeks, with the potential to be extended if necessary. The team will work closely with other agencies including relevant other social care partners and the third sector.

All professionals within the team have the necessary training and skills to complete a holistic generic assessment for any patient referred into the service for daily care. There is a great deal of trust and respect within the team ensuring involvement of necessary professionals in the patients journey at the correct time. Having all qualified staff trained in this way ensures that a comprehensive assessment of the individual's needs is carried out in a timely manner by the most appropriate professional. They will then plan with the patient through use of good conversation, realistic and achievable personal outcomes, empowering the individuals to maximise independence and encourage self-management.

Alongside the daily care element of intermediate care is the general rehabilitation provided by our skilled group of AHP staff and support workers. As mentioned previously they support a range of individuals with complex conditions to maintain function and as safe an environment as possible at home. They provide the individual with treatment, advice, equipment if necessary and signposting to appropriate service ensuring they have the necessary tools and skills to self-manage. All staff within the team are trained in personal outcomes and good conversations.

During 2020-21 we developed in introduced virtual Pulmonary Rehab classes accessible to all and were able to provide mobile technology on loan if required to support the programme.

Covid-19 has made us develop our ICT and Hospital at Home services differently providing more efficient ways of working and triaging. Use of Near Me for consultations following more detailed telephone triage if required. Greater developments with ehealth offering better digital solutions for record keeping and patient consultations. Staff had access to laptops or ipads so were able to work in the community.

Ward Allied Health Professions (AHPs)

The occupational therapy and physiotherapy service provides assessment and rehabilitation to all the community wards across Fife. These are downstream wards and occupied by a combination of people requiring rehabilitation, management of discharge home to complex care packages. There are a total of 5 Hospital sites including 2 stroke rehabilitation wards. The non-stroke beds include a combination of people with other neurological conditions, fractures and any other condition which requires a community bed. At any time, a significant proportion of the patients have a cognitive impairment or dementia. There are rehabilitation areas on or near to the wards areas in all of the hospitals.

The physiotherapy team provide individual assessment and rehabilitation on an individual and group intervention sessions to the patients to work towards personal outcomes and discharge home.

The occupational therapy staff provide rehabilitation to optimise patients' occupational performance (ability to perform valued activities). This includes both rehabilitation methods to restore physical and cognitive function and to compensate for reduced function with adaptive techniques and equipment training.

Day Hospitals

The service provided includes a multidisciplinary assessment for those with medical and rehabilitation needs, medical frailty clinic by GP fellows, outpatient physiotherapy for older people able to attend the service and medical clinics for people presenting with more complex needs which require the input of geriatricians. The active benefit of the ARC approach is the coordination of services which has led to a more efficient and targeted use of staff resource and reducing the number of return attendances for patients while sill achieving optimum outcomes in personal outcomes, health and wellbeing.

Community Occupational Therapy

The Community Occupational Therapy service works with adults and older people who are experiencing functional difficulties with activities of daily living to enable them to be as safe and independent as possible.

Assessment of an individual's needs can be carried out either by telephone, or in person by a member of staff carrying out a home visit. Telephone assessments have become an increasingly valuable way of meeting people's needs during the pandemic, but where a service user has more complex difficulties or telephone communication is not possible, home environment visits are still required.

Following an assessment, the Community OT service can offer to support people in a number of ways. These include teaching the person and/or carers to carry out their activities in a different way or adapting their property with equipment and/or adaptations to make their home more safe, suitable and appropriate for them. The Community OT service works closely and in partnership with many other professions such as:

- Housing,
- Social Work,
- ICASS,
- Community stores, and
- Acute services

To meet people's needs and much of the effectiveness of our input is as a result of partnership working and good communication.

Community Occupational Therapy has a stretch aim to "reduce and sustain the average longest wait for the Community Occupational Therapy waiting lists to no more than 200 days." Our aim is to reduce the number of people waiting and the length of time that people wait, while continuing to provide a quality service within budget.

The target that has been set is ambitious, however it has been achieved on several occasions and the service continues to strive towards achieving this target. There was a spike in the longest waiting case average for April 2020 and this can be attributed to the Covid-19 pandemic. The service has worked diligently month on month to continue to reduce this wait despite the challenges that have been faced during these unprecedented times. As at November 2020 the longest wait average was 209 days which is 9 days or 4.5% above the target that has been set.

One of the ways we achieved the above was to be creative in how we continued to deliver assessments throughout the Covid-19 restrictions.

Prior to Covid-19, the Community Occupational Therapy Service had already refocused our initial telephone screening or “duty” process to enable us to provide some equipment and minor adaptations for those with non-complex needs without waiting for a full home assessment. The aim was to reduce the waiting time for those with complex needs and enable their needs to be met faster.

This put us in a good place for dealing with the challenges of Covid-19. The need to reduce home visits has encouraged us to expand the range of provisions we support without a home visit. This has required staff to draw on experience and develop increased skills in effective conversations and questioning to elicit adequate information to determine that it is appropriate to make a provision - without having visually seen the person or the environment. Accessing digital solutions to maximise our potential to reduce home visits while still providing a service was challenging. We had to make a business case for smart phone devices which was a lengthy and time-consuming process but ultimately successful. We also initially had no access to NearMe for remote video consultations and access to WhatsApp took time to be agreed.

The focus of Community Occupational Therapy assessment and intervention is around how a person carries out day to day activities within their home environment. Generally, the most effective way to do this is to carry out visits to the home and so in urgent and high-risk situations we maintained home visits. Early in the pandemic we purchased uniforms for our staff and ensured that they all had access to the required PPE. The vulnerability of many of the service users we work with required us to limit the number of times we went out to a home and the number of people present on the visits.

Covid-19 restrictions impacted on the ability of inhouse contractors to complete major adaptation work, with risk assessments and single contractor working resulting in work taking longer.

Next Steps

- Remodelling for Day Hospitals
- Greater integration of frailty services
- Development with Fife Council Housing Occupational Therapy to integrate into the Community Occupational Therapy service
- Working with Housing on One Stop Shops
- Ongoing development of Pulmonary Rehab with virtual classes and other models and respiratory services to support long Covid-19. The National Video Conferencing Service was used as a platform as it provided a secure connection for use with patients. Patients were asked for feedback and the first cohort consisted of 20 patients across Fife, 5 classes of 4 patients. 16 patients completed their virtual course of pulmonary rehabilitation, which is a significant improvement in completion rates versus face-to-face classes. Attendance rates were also higher. Due to the ongoing Covid-19 pandemic we are continuing to run our virtual classes and will do for the foreseeable future. Once restrictions allow a return to face-to-face classes, it will be as a blended model of both virtual and face-to-face for those who do not have the relevant technology.
- Ongoing use of new systems offering more effective triaging.
- Online waiting lists to maintain communication across services offering transparency.
- Continue to review use of digital solutions and other ways of working to reduce waiting times – this will now be primarily for efficiencies as we move beyond Covid restrictions. We now have access to Near Me and are looking at where this best adds value for service users and the partnership.

Fife Equipment Loan Service

Fife Equipment Loan Service (FELS) is based within Fife Council's Bankhead Depot in Glenrothes. Building Services by way of a Service Level Agreement with the Health & Social Care Partnership provide operational management of the storage, delivery, collection, refurbishment and recycling of community loan equipment. The store loans equipment to help support people to live as independently as possible in their own home. Equipment such as beds, hoists, bathroom equipment and specialist children's equipment can support timely discharge from hospital and prevent admission into hospital or long-term care. In October 2019 a procurement exercise was undertaken to source a new online equipment ordering and stock management system that would meet not only the current but future needs for all stakeholders of the Equipment Store. Using mobile technology, the chosen system, TCES Community, will enable more efficient stock control including the tracking of equipment to ensure the continual safety of all our service users and will also provide an improved interface for all clinicians. The software built into the system can be used to support the Fife Equipment loan store to further develop new improved ways of working to promote safe, sustainable and person-centred health and social care services in Fife.

Key project statistics

Since going live on the 1st April the data from our new system shows us that the loan store has:

Completed 29,193 orders

Reaching 10,503 service users.

65% of these orders are deliveries of equipment which have supported people to remain in their own homes and communities

The remaining 35% are uplifts for equipment that can then be refurbished.

The project was carried out in partnership with Fife NHS and Fife Council including Education Services. Despite the many challenges of Covid-19 the new system was successfully implemented on time for the 1st April 2020. This was a testament to committed integrated working by the many different services involved. The main challenge was around the roll out of face-to-face training with all the clinicians who use the system to order equipment for their patients to support hospital discharges and prevent admission into care settings. We have over 700 clinicians using the system therefore we decided to do direct training with a smaller group of staff designated as TCES champions with the plan for these champions to roll out face-to-face training to their Teams. Unfortunately, due to lock down restrictions all the training had to move online. Although this was challenging for all the Teams involved, staff very quickly adapted to the new way of learning and successfully gained the knowledge required to use the system effectively. Additionally, we were unable to have CSS our contractor spend time with the store staff during the crucial going live week. However due to the strong relationships built up during the previous 16 weeks of the project we were able to navigate all the inevitable initial set up snags with very little disruption to the normal day-to-day running of the equipment store which has been able to successfully remain fully operational throughout Covid-19.

This system is accessible to NHS and Fife Council staff including Community Occupational Therapists, Care at Home Services, Physiotherapists, Community Nursing and Education staff to order, arrange delivery and the uplift of community loan equipment.

Next Steps

- TCES Community offers the opportunity to further develop the service the stores provides to support people to live as long as possible in their own homes and community settings. The enhanced data it produces will help to inform decisions about the types of equipment required to maintain people's mobility and independence.
- Service users can already directly access small items of equipment using the "Smart Life in Fife" portal which are then delivered by Fife Equipment Loan Store. Future developments include the possibility of adding the "small adaptations service "onto TCES Community, providing prescribers with the ability to order equipment and arrange adaptations all from one single system.

Care Homes Replacement Programme

Methil Care Village: the pandemic meant that the project was delayed by 8 months and construction at Methil did not get underway until November 2020, however, it is now progressing well. Residents of the existing Methilhaven Home have been enjoying seeing photographs and film of progress with their new home and have been choosing names for each of the residential units within the home. They are looking forward to helping decide on colour schemes and furnishings for the new home.

Cupar Care Community: approval was granted on 18th February 2021 for the replacement for Northeden Care Home in Cupar. This will be a 24-bed care home with 12 supported housing flats for adults with additional support needs. The building will also contain accommodation for Adult Services' Community Support Service, older people's day service and a hairdresser. Residents of the existing Northeden House have been very pleased with the initial designs and particularly liked the proposed enclosed balconies and garden areas.

Anstruther Care Village: approval was granted on 7th January 2021 for the replacement for Ladywalk Care Home in Anstruther. This will be a 24-bed care home with 12 extra care housing flats for older people and two specific needs bungalows in the grounds. The main building will also contain a café/ drop-in facility, hairdressers and day service for older people. The Design Team are now working on the design for the new building.

Next Steps

- Near completion of Methil Care Village, now estimated to be May 2022.
- Submission of Planning Application for Cupar Care Community in May 2021.
- Ongoing development of the design for Anstruther Care Village. Working toward Planning Application submission in December 2021.

Support for Unpaid Carers

We continued to deliver support for unpaid carers in Fife albeit with a significant change in the approach and method of delivery. Very few of the commissioned voluntary sector partner organisations ceased their support for carers except for those that offered short breaks in residential or day settings. Most organisations adapted their method of delivery to include telephone support for carers (including assessment of their needs for support) and some introduced video consultations and support to continue with a form or face-to-face support.

New support for unpaid carers was commissioned in the following ways:

- Carers of people with sensory impairment, and carers who themselves are affected by sensory loss.
- Carers of people with mental ill-health and support to maintain and improve carers own mental health and well-being that supports their ability to cope and thrive as a carer.
- Support to help understand the benefits of Powers of Attorney and assistance/guidance to secure the same for the persons they care for, proactively, or secure Guardianship after the fact.

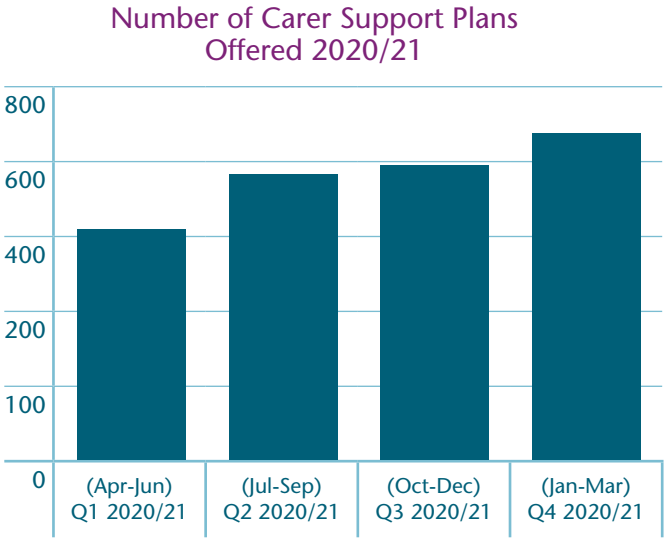
The change in approach to supporting carers meant many carers were unable to access to the support they had previously benefitted from particularly short breaks from their caring roles. Fife Carers Centre reported that carers coped well at the start of lockdown but as time wore on carers' newfound confidence in their own abilities and resilience was tested. Carers have reported suffering significant strain and stress during lockdown and this presented a major challenge with the lack of breaks from caring, an impact that will remain in place for a significant time to come.

There were very significant delays in decision-making regarding the investments and improvements proposed that were intended to enhance support for carers. Final decisions were only reached in November 2020. These delays, while understandable at the start of the lockdown, likely impacted on our ability to support carers in meaningful ways sooner.

During the year the previously agreed locality support service was introduced across Fife in partnership with Fife Carers Centre. As this investment took place at the start of lockdown the role of these staff was flexed to support unpaid carers in different ways including specifically delivering PPE to unpaid carers.

Carers Week 2020 was held virtually with a range of stories and articles posted online and in social media with the aim of making caring more visible and recognised as critically important. This week was also used to launch new support including self-help whereby carers can access much of the support they might need using resources we have secured for their use, particularly information on our web-site and through the Carers UK digital resource for carers which we purchased for carers to access at a time and place of their convenience.

Operational Teams have a responsibility to offer carers their own support plan. The chart shows the number offered during each quarter of 2020/21



Next Steps

- A series of improvements are proposed for 2021/22 which remain subject to decision making processes. These focus on practical support for unpaid carers specifically in supporting them to achieve a better balance in their own lives through breaks from caring. Proposals also include enhancements in support for young carers as well as community-based support in each locality in Fife whereby carers in these localities would propose the support that best meets their own needs.

Community Pharmacy

Scottish Government, at the outset of the Covid-19 pandemic lock down, directed all Community Pharmacies to remain open to provide essential services to the public. Community Pharmacy responded to this instruction by continuing to keep their doors open to the public throughout the pandemic and to date NHS Fife has experienced no community pharmacy closures.

Maintaining this essential service throughout the pandemic has been extremely challenging. Community Pharmacy in NHS Fife and across NHS Scotland must be commended for continuing to serve the public and respond to the many changes necessary during this difficult time.

The most notable challenge in continuing to provide pharmaceutical services in the initial stages of the pandemic was the unpredicted public demand to obtain regular medication. Increased prescription ordering resulted in pharmacy workload almost immediately doubling, whilst the necessary creation of queuing systems to accommodate physical distancing with this increased volume was incredibly difficult to manage. Many pharmacies experienced a lack of understanding from the public at this time and some experienced unacceptable abuse requiring police involvement. This increased demand also put strain on the supply chain and created some transient medicine shortages.

Physical distancing not only created queues but also meant an immediate unplanned and largely unsupported reconfiguration of premises, where Community Pharmacies introduced innovative solutions in managing infection risk such as Perspex screening, sectioning of space and creation of one-way systems at a time where guidance on such matters was not

yet considered and yet required implementation at the height of patient demand. Physical distancing meant there was a necessary reduction in the use of private consulting spaces. This lack of private consultation space resulted in a reduction in the provision of confidential consultation for advice and treatment such as emergency hormonal contraception provision and urinary tract infections. Smoking cessation support proved difficult to continue due to the service specification requirement to monitor carbon monoxide (CO) levels

Revised models of service provision due to Covid-19 in other areas of NHS Fife also impacted and provided challenge to Community Pharmacy. The necessary increase in remote triage by prescribers, most notable in the initiation of centralised models of emergency care such as the Covid hub and emergency dental hub practices, but also in many other areas of patient triage within NHS Fife, such as CAMHS, and Hospital @ Home resulted in the requirement for prescriptions to be provided in an emergency supply model. Patients are triaged and advised to attend their local pharmacy while prescribers emailed/faxed the prescription details with a "wet signature" script to follow. Legal requirements are for these prescriptions to follow within 72hrs. Royal Mail disruption and initial teething problems with establishing communication channels resulted in a significant increase in the administration time required within pharmacies to cope with these models at a busy and challenging time.

In a letter to Chief Executives on Covid remobilisation plans from Scottish Government, boards were asked to work with local contractor committees to support the national roll out of the NHS Pharmacy First Scotland service.

Launch of Pharmacy First

The new NHS Pharmacy First Scotland service, which replaces the current Minor Ailment Service and current Pharmacy First services, commenced in all community pharmacies from 29 July 2020. Scottish Government indicated that this is a key deliverable for pharmacy remobilisation. This redesigned minor ailment and common clinical conditions service is available to all patients registered with a GP in Scotland or living in Scotland and allows advice and treatment, and where appropriate referral, to be provided free of charge. The focus is on increasing access to community pharmacy as the first port of call for managing self-limiting illnesses and supporting self-management of stable long-term conditions in and out of hours, thus offering further support to patients in the unscheduled care period e.g. evenings and weekends. The service improves pharmaceutical care and contribute to the management of patients within a multi-disciplinary team.

Since the launch of the Pharmacy First, Community Pharmacies across Fife have on average consulted with 2775 patients per week under the service, providing essential treatment and care and ensuring that patients receive the right care in the right place by embracing and utilising the service fully. Under the Pharmacy First service, Community Pharmacists are able to provide two essential prescription-only medications previously only available from the patient's GP or practice prescriber for treatment of urinary tract infections and impetigo, reducing further the need for patients to attend their medical practice. The Pharmacy First service in Fife continues to build and expand providing a major benefit to patient journey and pathways of care.

Next Steps

- The Pharmacy First service continues to develop with additional conditions being added in for treatment, notably in July 2021 treatment will begin for shingles and skin infections, increasing further the impact of shifting the balance of care from GP practice to Community Pharmacy. "Pharmacy First plus" is a new service introduced to make use of Community Pharmacist independent prescribing skills. NHS Fife has 8 pharmacies signed up to extend current pharmacy treatments available and the board will encourage more participation as clinical skills are developed.

Effectively Managing our Workforce

Implementation of Health and Care (Staffing) (Scotland) Act 2019

In Late January 2021 the Cabinet Secretary for Health and Sport wrote to Chief Executives of all Boards acknowledging the implementation of the Health and Care (Staffing) (Scotland) Act 2019 was paused due to Covid-19 and outlined the Scottish Governments commitment to the introduction of the Act in the next Parliament. The Act will stipulate that it is the duty of every Health Board to put and keep in place arrangements in relation to staffing and recording and explaining decisions that may conflict with clinical advice. Although the implementation of the Health and Care (Staffing) (Scotland) Act 2019 has been delayed by the Covid-19 pandemic, processes were in place ensuring the key principles and intent was being applied in practice.

Over the winter surge period and the ongoing workforce pressures due to Covid-19 pressures, a workforce mobilisation hub, overseen by a Head of Nursing with support from Lead Nurses, coordinated staffing information from across all Community Health Services and the Care Homes to ensure these areas had sufficient staffing and to provide assurance to the Board Nurse Director, all areas were able to deliver safe, effective and patient centred care in line with the organisational priorities.

Next Steps

NHS Fife and Fife Health & Social Care Partnership Joint Interim Workforce Plan 2021/22 allows the organisation to pause and reflect and plan for future years taking learning from the response to Covid-19 and the implications for the workforce beyond 2022. It is important to recognise the need for a flexible and mobile workforce as we learn to live with Covid surges and outbreaks in the months and years to come and ensure this is reflected in future workforce strategies. This is particularly important in relation to safe staffing and to ensure we have the right infrastructure to develop our governance of the legislation over this year and the systems and processes in place to give assurance that advice and decisions we make are informed and evidence based.

Priority 4
Living well with long term conditions

We are committed to building on the work already started in Fife to support adults and older people with complex care needs, who are accessing both primary and secondary care services most frequently. We are developing and supporting a more integrated and earlier approach focussing support pro-actively with patients who would benefit from this which includes early identification and comprehensive assessment in case co-ordination.

High Health Gain / Community Complex Care Teams

These teams support more integrated and earlier approaches for adults and older people who are at highest risk of decline in their health & wellbeing / reduce the proportion of people requiring an unplanned admission following a High Health Gain intervention.

Every patient identified as High Health Gain Complex Care who has had an acute admission is supported by the Community Complex Care Teams (Respiratory & Frailty) for early supported discharge.

High Health Gain (HHG) admissions data is captured at 6-month intervals i.e. number of hospital admissions 6 months prior to HHG referral date and number of hospital admissions 6 months post HHG referral date. Between April 2020 and October 2020, a total of 69 referrals were received (respiratory and frailty combined). The number of hospital admissions prior to HHG referral for these 69 patients was 120 admissions. The number of hospital admissions 6 months after referral and following HHG input was 78 – a reduction of 35%.

From November 2020 to February 2021, a further 52 referrals were received with 85 prior hospital admissions. The results of High Health Gain input, and resultant post hospital admissions, is yet to be recorded.

For a number of months during the Covid-19 pandemic, the focus of support was given to respiratory complex care patients. No referrals for frailty were received in May 2020 and only one in June 2020. Frailty referrals began to increase again from July 2020 onwards and patients were supported using a High Health Gain approach.

Referrals received	No of referrals in month	No of hospital admissions 6 months **prior** to referral date.	No of hospital admissions 6 months **post** referral date.	Percentage reduction
Apr20>Oct20	7	12	5	-58%
May20>Nov20	1	1	0	-100%
Jun20>Dec20	6	14	11	-21%
Jul20>Jan21	11	18	12	-33%
Aug20>Feb21	14	21	18	-14%
Sept20>Mar21	19	31	21	-32%
Oct20>Apr21	11	23	11	-52%
Sub Total	**69**	**120**	**78**	**-35%**
Nov20>May21	17	20		
Dec20>Jun21	15	20		
Jan21>Jul21	6	19		
Feb21>Aug21	14	26		
Sub Total	52	85		
Total	**121**	**205**		

Palliative and end of life care / Community Complex Care

The Community Respiratory team continues to receive referrals from multiple H&SCP agencies and acute services who have identified patients who are at high-risk of decline and/or admission to hospital. Referrals over last year were 92 and all of those were accepted. The team who are small in number have a rolling caseload across Fife of approximately 100 patients who have complex respiratory conditions with a heavy symptom burden. They are offered a multi-faceted approach following a HHG/Respiratory assessment. Integration of services with a case management approach is key to supporting these patients, carers and families at home. The team work with all appropriate agencies including H&SCP, acute and voluntary services, and use appropriate strategies required to allow a wraparound service to the patient's needs. This is a truly patient-centered led service with a high proportion of patients requiring palliative and end of life care services. The team provide early supported discharge which has had to be adjusted due to Covid-19. The team are currently unable to visit patients whilst in the acute hospital, but by utilising the Trak system, the team are able to identify patients as soon as discharged and contacted as soon as possible to follow up at home to help prevent any readmission.

The Community Respiratory team supports all patients to complete advanced care plans if they wish. For those patients who decline, the Community Respiratory Team is encouraged to support these patients' wishes. The team offer extensive support to carers (local anecdotal evidence) both through formal channels as well as via our advice line which takes an average 144 calls per week. This phone line is available to patients' carers and families as well as health and social care colleagues for advice. The team work with all agencies to allow patients who wish to die at home to do so, increasing the team input as required in line with other services. In the last year the team have established good links with specialist palliative care services both in Fife and Tayside as well as acute respiratory services in Tayside to support patients in the Northeast of Fife to ensure this is a Fife wide approach.

Next Steps

- Every patient who is afforded a case management approach may be offered a High Health Gain approach if appropriate.

Fife Specialist Palliative Care Service

Specialist palliative care in Fife is provided by an expert multi-professional team who have undergone recognised training and have specific expertise in supporting people who have unresolved complex physical, psychological, social and/or spiritual needs that cannot be met by their usual care provider. In Fife, specialist palliative care services comprise:

- Two hospice inpatient units (currently 1 unit due to pandemic impact)
- An acute hospital support team at Victoria Hospital
- A once-weekly specialist palliative care outpatient clinic
- A community specialist palliative care nursing team (outreach team providing Hospice at Home model during pandemic)
- Day services based at Victoria Hospital (not currently operating and environment will not support previous model)
- Children and families service and adult counselling service

During Covid-19, Fife Specialist Palliative Care flexed the service to meet the needs of patients. An outreach service has ensured that patients have been cared for in their homes. For those patients who have required end of life or palliative care in an inpatient facility, the VHK hospice and community hospitals have been utilised.

Next Steps

- Reassess and review Day-service model
- Inpatient / outreach service delivery model to ensure person-centred approach
- Continue to work in partnership with community services and 3rd sector partners

Fife Macmillan 'Improving the Cancer Journey' Service

Improving the Cancer Journey (ICJ) was launched in September 2018 and since then 1692 people have engaged with the service. ICJ was established to address the multifaceted consequences of receiving and living with a cancer diagnosis. Since its inception it has offered holistic, individualised support to all local people diagnosed with cancer. As the first integrated social and health care service in the UK to deliver beneficial outcomes for people affected by cancer, its approach has been referenced in the National Cancer Strategy (Beating Cancer: Ambition and Action 2016).

In response to the Covid-19 pandemic the ICJ service stopped all face-to-face visits on the 23rd March and continued to offer people affected by cancer, telephone and/or Near Me appointments. ICJ employees were provided with suitable IT equipment to enable working from home (this continues to be the norm). From March to September the ICJ Service Manager worked 3 days per week as the central point of contact for personal protective equipment between National Services Scotland and H&SC social work/social care services.

Progress that has been achieved between 1st April 20 and 31st March 21:

- The ICJ team introduced the offer of Near Me – Between 29/3/2020 and 14/2/2021 there have been 65 NM calls.
- Building on the partnership working with Macmillan benefits advisor (CARF) an information sharing protocol is now in place between ICJ and CARF.
- A Data Protection Impact Assessment is in place to enable data from the electronic Holistic Needs Assessment (eHNA) to be transferred to POWER BI for monitoring and reporting purposes. This is a joint project with Business Technology and H&SCP
- Recognising that the workers were not engaging with stakeholders face-to-face it was agreed that the team would create an ICJ quarterly newsletter to increase awareness of the service delivery during the pandemic.
- The Team developed a Fife ICJ information booklet for People Affected By Cancer.
- Over 600 people engaged with the service.

Next Steps

- Test of Change – The aim of the TOC is to offer a single point of access for health and social care professionals to refer/signpost people with a long-term condition who require additional support to live well in their community.
- Evaluation – post eHNA survey to people who engage with the service to Health Professionals to refer to ICJ (Health professional survey, end of 2021).
- Pathway development – stakeholders to agree how to position ICJ as an "opt out" service.
- ICJ Service to offer a blended approach - face-to-face, telephone and Near Me appointments.

Short Breaks Service

The personal outcomes approach to assessment and supporting planning continues to be evidenced in our Short Breaks Service for Adults (65 years and under). The team provide information to supported individuals and their families/carers to assist them to access creative and innovative short break provisions, using their individual short break budget and their chosen option through self-directed support.

2020 was an extremely challenging time for many, including unpaid carers who due to Covid-19 restrictions were unable to access any planned respite to provide them with a much-needed break from their caring role. Many building-based short break resources were closed and the requirement to "stay at home" meant that many alternative, creative breaks were not an option.

As part of our remobilisation of services, short break providers worked closely with Health & Social Care staff and Public Health to introduce additional health and safety measures which allowed them to welcome visitors back in October.

Due to the implementation of additional health and safety measures, providers have had to adapt their service delivery models. For many this has proved extremely challenging. It has meant additional consideration of numbers that can supported at one time, consideration of the outcome of Covid-19 testing (a pre-requisite prior to breaks taking place) and a change in how their service can be delivered. Accessing outdoor activities was much reduced; which meant that individuals' experience of their short break was very different.

As highlighted, the number of individuals who were able to access their break was much reduced which has put considerable strain on families and carers. Both the short breaks team and the short breaks providers tried to alleviate this as much as possible through telephone contact and ensuring that when resources did become available, those in the highest need of a break, were given priority. This was managed through our remobilisation of services planning.

We have also seen a reduction in the choice of available resources which has meant some individuals and families have not been able to access their usual short break facility. This has proved particularly challenging for individuals with high, complex care needs.

For some, there remains anxiety about returning to building based resources and the Short Breaks team have been working with individuals and their families to look at creative ways in which breaks can be achieved using their short break budgets.

Examples of creative use of personal short break budgets

- Summerhouse with some furniture
- Boxing ring in a shed
- Lodges
- Caravans
- Therapy sessions/ services (unavailable through statutory sources)

Next Steps

- Due to the challenges highlighted, the short break team will focus in the coming year on identifying new resources and facilities which offer both creative and building based support. We will work with providers to identify if alternative models of service delivery can be explored e.g. care in the home rather than going to a building, allowing the carer to take a break away from the home, working with our commissioning managers to address the gaps in service provision as well as continuing to support individuals and families to access breaks which meet personal outcomes as well as support carers to continue in their caring role.
- We plan to introduce a post break review for each individual and family to capture their thoughts and opinions on how successful (or otherwise) their break has been – both from the perspective of the supported individual and from their carer. This will help to evidence where outcomes are being met and where more work is required. It will also provide evidence of where creative breaks have been tried and have been successful, which we hope will help individuals and families who may be anxious about trying something new.

Supporting those living with HIV

The HIV Multi-disciplinary team c developed holistic healthcare provision for people living with HIV through:

- regular physical and mental health monitoring such as Qrisk3 (which calculates a person's risk of developing a heart attack or stroke over the next 10 years), QFrax Frailty score (to assess the 10-year probability of incurring a hip or other major osteoporotic fracture) PHQ (Depression questionnaire) and GAD (Generalised Anxiety Disorder) scores
- setting up referral pathways to appropriate services.
- Improving and encouraging access to dietetic and mental health services embedded within the HIV multidisciplinary team.
- Management of multi morbidity in an aging HIV cohort for example through outreach work care home visits by specialist nurses.

Fife contributed to Scotland achieving the Global 90/90/90 HIV target by 2020 (90% of people with HIV diagnosed, 90% of diagnosed are on treatment and 90% of people treated have an undetectable viral load).

The national and international aim for HIV is now for the elimination of transmission by 2030. As well as effective treatment for those diagnosed with HIV this aim will require a further shift towards prevention and testing of at-risk populations. Two key services that operated throughout 2020/2021 in Fife were the Pre-Exposure Prophylaxis (PrEP) programme which prevents the sexual transmission of HIV and The Home Testing partnership with HIV Charity Terence Higgins Trust Scotland.

256 people are living with HIV in Fife (Public Health Scotland, HIV in Scotland: update to 31 December 2019. Published: 23 June 2020)

1286 HIV related appointments were conducted in the year 2020/21. 566 of these were in the 50+ age range (NASH dashboard 2021)

The impact of the Covid-19 pandemic on new initiation and ongoing treatment of people living with HIV was challenging and patients themselves experienced anxiety about the effect of the Covid virus on their general health and HIV treatment. The challenge of managing increasing numbers of home visits for isolated and vulnerable patients looks likely to continue.

Next Steps

Embed the mobile and outreach model of service delivery to increase testing and treatment access.

Continue to develop the work with homeless populations to offer increased access to basic healthcare and increased access to testing treatment and care

- Initiating look-back exercise following a late diagnosis in order to learn and reduce the number of future late diagnosis.

83 people received PrEP during 2020/21 of which 14 were new starts on the treatment.

175 people ordered free HIV home testing kits online from our partners THT Scotland providing a vital service during lockdown. 88% (152) of tests were ordered by men of whom 85% (129) were men who have sex with men (MSM). Significantly 28% (49) of tests were ordered by people who reported they had never tested before. This suggests this service increased awareness and ease of access to HIV testing in Fife.

Rheumatology

Despite the redeployment of staff to support patient Covid wards, including the Lead Nurse to the Workforce Mobilisation Hub, the service has worked incredibly hard to continue to manage all patients as well as continuing its journey of improvement.

Covid has had a significant impact on all service provision within the Rheumatology service. For many months there has been a limited capacity to manage any patients on a face-to-face consult basis. However effective planning, review and service redesign has helped reduce the impact on patients.

The development of our Self-Management pathway has been beneficial in managing patient care and expectations during this very difficult time. The Self Care Pathways have been embedded into the service as a business-as-usual approach to managing new patients.

The service has implemented phone and Near Me consultations to supplement urgent face-to-face consultations and are currently using a blended approach to home working to ensure social distancing and staff safety within the base.

Rheumatology - Total Waitlist	Oct-20	Mar-21
General Reviews	2799	2487
Spinal Reviews	226	194
CTD	376	332
Vasc	61	50
ADOL/YAC	25	24
Total Waitlist at Mar 2021	**3487**	**3088**

The Nursing team have been using Near Me technology to see consultant reviews for patients who historically been reviewed at between 4-6 months, allowing Consultants to utilise their capacity for more urgent complex patients

The service has also implemented Paperlite, which now means all our documentation is uploaded to the Clinical Portal reducing any clinical risk associated with paper notes.

Next Steps

- Continue to provide patient-centric care via well-developed pathways which will ensure patients are seen by the most appropriate member of the team.
- Further embed the Self-Management ethos of delivery for new patients
- Recruit to the Consultant vacancies/develop an advanced practice workforce which will meet waiting times without compromising care

Priority 5
Managing resources effectively while delivering quality outcomes

The financial position for public services continues to be challenging and the Integration Joint Board must operate within significant budget restraints and pressures. It is therefore important that resources are targeted at the delivery of the priorities within the strategic plan.

Covid-19 restrictions have meant significant change in the way in which health and social care services operate, which services are offered, and how they are delivered.

The long-term impact of Covid-19 is an unknown. Inadvertent consequences on the local community are possible and services will be required to continue to adapt and change to meet emerging needs, for example, in mental health as a result of isolation or care for those with long-Covid symptoms.

The new Mental Health Strategy for Fife (2020/2024) takes full account of the recommendations of the National Mental Health Strategy, which emphasises the need to build capacity within our local communities and reduce the reliance on hospital beds. Work will continue on this Strategy in 2021/22, taking cognisance of the expected increase in demand.

The continued increasing demand on our services due to Covid-19, demographics and people living longer with complex needs is also a factor for consideration in developing our strategic plan. Along with the desire to bring people back to Fife and out of hospitals into a homely setting, this will require an investment in social care staff, recruitment, and a focus on continued integrated working and closer working with our Partners in the Third Sector.

A major restructure is underway. Three new Heads of Service are now in post and the new integrated services will be delivered within one of the following:

- Integrated Primary and Preventative Care Services
- Integrated Community Care Services
- Integrated Complex and Critical Services, or
- Professional and Business Enabling Services

The restructure will require transformation of services and development of new ways of working.

Increasing the Use and Application of Technology

Working in partnership with Just Checking we have started work on the redesign of Overnight Support and introduction of Technology Enabled Assessment.

Introducing Technology Enabled Assessment encountered a few challenges, primarily as a result of Covid-19 which meant that the start was delayed until restrictions lifted a little in September and resulted in the timeline for implementation being adjusted. Just Checking worked with us through this and adjusted their own project timeline to accommodate the delay, allowing us to carry into the new financial year. We also had to pause whilst restrictions were back in place, after the festive period.

Despite these delays, the Partnership was able to start using technology as a support to our existing assessment and review process. Staff from Health and Social Care have been working in partnership with Just Checking in two areas in the west of Fife. One is in the Older People's Service to support the assessment of new referrals received by the service, from both individuals with existing packages of care and those without and the second, working with our Adults team in the Dunfermline area to support the review of overnight support.

The range of technology enabled care has only recently been explored in Fife and we are using this as an opportunity to identify if our current models of support continue to meet individual need and outcomes. It also offers the opportunity to consider circumstances where alternative digital solutions can provide less intrusive models of support; enabling and empowering people, using technology, to live more independently.

Due to pressures within operational Teams because of Covid-19, undertaking assessments and reviews following the Just Checking installations has proved challenging. There is significant work required to analyse the data and then once potential changes have been identified, to undertake a full social work review, liaise with families and carers then implement any change. This has taken longer than anticipated.

The project to review the overnight support, as was anticipated, has also been challenging. Many carers, families and service providers have raised concerns about the potential changes to some existing services, many of which have been in place for several years. Each circumstance is being considered individually; taking into consideration family concerns, the individual personal circumstances and health needs as well as provider nervousness about proposed changes. This has impacted on timescales, as additional time has been required to provide information and reassurance. This has, however, been crucial to ensure all parties feel involved and included in the process. The introduction of dedicated staff is being considered in order to overcome this as the project moves to others areas in Fife.

Next Steps

The reviews in the Dunfermline area are in the final stages and the intention is to replicate the process across Fife, the second phase being in Glenrothes. Work has started in preparation with Just Checking involved in demonstrations for Health and Social Care staff. Communication is being prepared for families as well as briefings for staff.

It is anticipated that this shift in the use of technology will provide the health and social care partnership with an evidence base to ensure these developments form a core part of future service redesign.

Inspection of Services

All registered Social Care services undergo inspection from the Care Inspectorate following their quality framework.

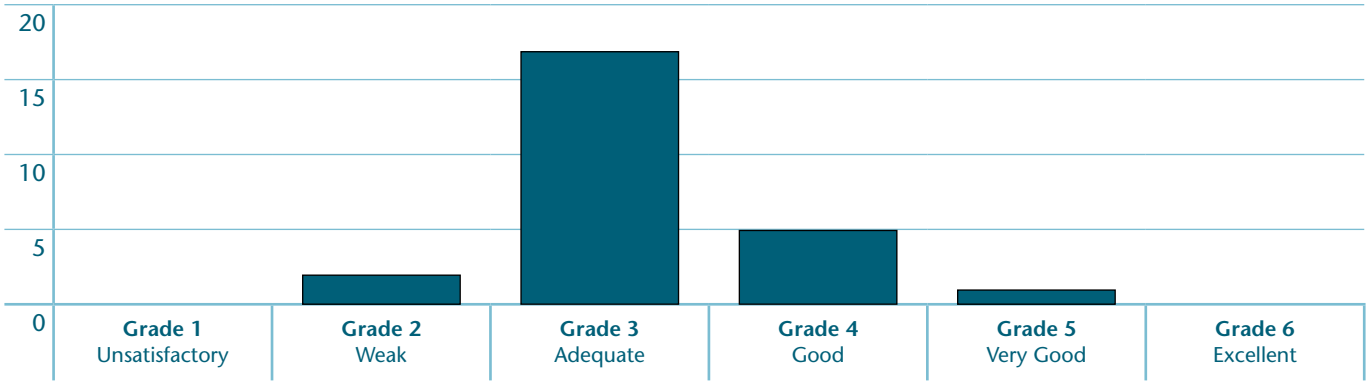
In order to robustly assess arrangements to respond to the Covid-19 pandemic and meet the duties placed on them by the Coronavirus Scotland) (No. 2) Act and subsequent guidance, the Care Inspectorate had to develop a new key question to augment their inspection framework placing a particular focus on infection prevention and control, wellbeing and staffing in care settings.

As a result, they moved to carrying out shorter more targeted inspections on these particular issues rather than the standard inspections. The overall number of inspections was reduced during 2020-21 due to the impact of Covid-19 and lockdowns.

No Fife Health & Social Care Partnership (Local Authority) registered services were inspected during 2020-21.

For all registered adult social care services (including Older People) within the Fife Health & Social Care Partnership area, delivered by the Voluntary and Independent Sector, 25 Care Inspectorate inspections were carried out. 6 of the 25 services (24%) that were inspected were graded 4 (Good) or above.

Fife Registered Services (Private/Voluntary)
Inspections conducted during 2020/21



Financial Performance & Best Value

The IJB commenced 2020/21 with an uncertain and challenging financial position due to the pandemic, with many services on hold, the workforce adapting to meet service needs and reacting to the pandemic. The IJB approved budget was set predicated on implementing an approved plan to deliver £13.759m of savings.

The savings package proved to be unachievable as many of the initiatives were put on hold due to continued restrictions and further lockdown arrangements. The non-delivery of £6.467m of savings was reported via the LMP and full funding was made available by Scottish Government.

Key pressures within the 2020/21 accounts are:

The significant increased demand for our services associated with an increasing population, in particular an increasing ageing population and increased complexity of care needs. Adult packages increased in year, due to Community Services, Day Care and Respite being placed on hold due to the pandemic.

The significant increased demand to ensure the flow from hospital discharges was effective and timeous in moving service users to a home or homely setting, to free hospital beds for admissions.

The inability to recruit staff to the Partnership which in some cases required higher cost recruitment for locum and agency staff to cover services.

Funding received from Scottish Government for additional Covid-19 expenditure, as requested through the Local Mobilisation Plan totalled, £29.233m and actual spend on Covid-19 was £26.038m. In addition, further allocations were received late in year for Winter and to fund on-going Covid-19-related pressures. The balance of funding was transferred to reserves to meet the expenditure expected to be incurred in early 2021/22.

The outturn position as at 31 March 2021 for the services delegated to the IJB are:

	Budget £000	Actual £000	Variance £000	Variance %
Delegated and Managed Services	612,103	582,460	(29,643)	4.8
Set Aside Acute Services	41,460	41,460	0	0.0

The IJB reported total income of £653.563m for the financial year 2020/21 and expenditure of £623.920, which comprised £582.460m. As income to the IJB exceeded expenditure in year, a surplus of £29.643m was reported. The surplus balance was transferred to reserves for use in 2021/22.

Within the favourable position of £29.643m, the core underspend is £7.083m. The main areas of underspend within the Delegated and Managed Services are Hospitals and Community Services £2.603m, Children Services £1.289m, Nursing & Residential £2.500m, Adults Supported Living £1.033m and Social Care Other £2.464m. These are partially negated by overspends on Homecare Services £1.243m and Adult Placements £1.189m.

Underspends in core areas are mostly attributable to staffing vacancies, many of which were difficult to recruit to due to Covid-19. Some services were paused, and staff redeployed to other areas.

The overspends in homecare and adult placements were a result of an increase in the number of packages to meet demands.

Financial Outlook

2020/21 has been an unprecedented year. The effects of Covid-19 are expected to continue well into 2021/22. Remobilisation and recovery will be key to moving forward, re-imagining services and continuing to embrace integrated working.

It is anticipated that all additional Covid-19 related costs will be fully funded from earmarked reserves and further funding from Scottish Government will be available when required and will continue to be requested via Local Mobilisation Plans (LMP). Fife IJB are committed to progressing agreed savings. Some services may have an increase in demand and our uncommitted reserves may be required to meet demands in these areas.

It is expected that Mental Health Services will see a surge in requirements and further funding is expected in 2021/22 to meet these demands and reduce waiting lists. Risks from deferred presentation and physical wellbeing will also increase demands on our services in the coming months.

Key areas of Covid-19 expenditure within 2020/21 were PPE, Financial Sustainability for Care Homes and Care at Home providers, additional staffing to cover isolation/shielding including use of agency and bank staff. Financial support to allow GPs and Pharmacies to open on public holidays. These supports are likely to be stepped down as restrictions ease, however this expenditure will continue to be closely monitored via the LMP.

The focus is now on recovery and reform and how to change services effectively. Services have shown they can adapt, and the pandemic has allowed the Partnership to quickly shift on areas of service redesign and improve integration. Business as usual was on hold as a result of the pandemic. However, as we begin to ease out of restrictions, workstreams will proceed.

An Integrated Transformation Board was created during the 2019/20 financial year. The terms of reference of that Board include responsibility for transformation across the whole system. Due to the pandemic response and recovery taking priority, the delivery of transformation and change this year has been postponed or slowed in many projects and transformation work, although redesign of some processes has occurred as a result of the pandemic response. However, positive steps have been made in appointing a Senior Leadership Team Lead for Transformation and discussion on refreshing both transformation projects, and the framework in which they operate, is underway.

The budget for 2021/22 has been set and balanced, with a savings plan of £8.732m in place to meet the budget gap. Project Teams will be created to ensure transformational change is progressed at pace across the partnership.

It is likely to be the case that some of the costs now being incurred could continue beyond this financial year and possibly even into the longer term. There will undoubtedly be an adverse impact on the level of funding made available to HSCPs due to the economic impact of Covid-19. As the recovery phases evolve, it will become clearer what some of these impacts are likely to be.

A financial strategy will be developed that addresses the various new and additional pressures that will face the Health and Social Care Partnership over next financial year 2021/22 and into future years.

The partnership must redesign services, focus on joined up working, and focus finite resources on delivering services which are sustainable over the longer term and focused on those with greatest need, whilst meeting the aim of shifting the provision of care to a home or homely setting.

The most significant risks faced by the IJB over the medium to longer term can be summarised as follows:

- the wider financial environment, which continues to be challenging;
- Covid-19 impact on the economy;
- the impact of demographic changes leading to increased demand and increased complexity of demand for services alongside reducing resources;
- difficulties in recruitment leading to the use of higher cost locums and agency;
- the cost pressures relating to primary care prescribing;
- the Transformation Programme does not meet the desired timescales or achieve the associated benefits;
- workforce sustainability both internally in health and social care and with our external care partners.

It is therefore crucial that the IJB focus on early intervention and prevention and changing the balance of care if we are to work within the available financial resources.

During 2021/22 an action plan to improve the 6 key features within the Ministerial Strategic Group self-assessment tool will be developed further and progressed. As part of this, the review of the acute set- aside will be progressed and steps made towards transferring this to the Health & Social Care Partnership. We will see the continuation of a whole system approach to delivering services and the Fife pound being utilised to deliver services that best meets the needs of the people of Fife.

Value for Money

Value for money is a key priority for the Partnership and all service redesign, purchasing, procurement and commissioning must comply with the best value and procurement guidance of the relevant bodies. It is extremely important that expenditure is managed within the financial resources available to ensure that they align to the 3-year financial strategy and our long-term objective to achieve financial sustanbility.

Future Priorities

Integrated Preventative & Primary Care Services

During 2022 we will be taking forward the following priorities:

- Continuing the implementation of the Primary Care Improvement Plan and Memorandum Of Understanding 2 completing phase two of Community Treatment and Care Services as well as pharmacotherapy and embedding vaccination transformation towards business as usual. Also looking to improve the sustainability of GP delivery through targeted resourcing and actions. Focus will include clearing the backlog in dental services.
- Continuing to monitor and refine the impact of the redesign of urgent care in order to increasingly treat the right person in the right place at the right time.
- Implementing the improvement actions from the strategic review of immunisation in Fife to bring all immunisation together into a single strategic programme for the people of Fife.
- Exploring models of Allied Health Professional delivery to maximise on access to services.
- Reviewing children's services in order to establish robust service delivery and actively fulfil a role as part of a multi-agency approach to child protection.
- Developing our approach to early intervention and prevention as part of reviewing Fife's localities and commissioned service delivery.

Integrated Community Care Services

2022 will be an exciting year for Community Care Services. Our overarching principle for the services is that everyone in Fife is able to live longer healthier lives at home, or in a homely setting. We will focus on Early Intervention & Prevention and in particular Technology enabled home-based care, targeting wellness support for those who are most frail and build capacity within our services. We also will ensure person-centred transfers of care and support enablement and rehabilitation, support cares and empower communities. To ensure the success of our home first principle, we will build responsive, integrated and sustainable systems with coordinated case management and care navigation. Community care services are excited to be embarking on this transformational programme and I look forward to realising the benefits for the people of Fife in the months ahead.

Integrated Discharge Hub & Community Patient Flow

Establishment of the Home First Oversight Group to provide leadership and direction of the delivery of a 'Home First' strategy for Fife.

Community Nursing: District Nursing & Hospital@Home

Transforming Community Nursing: In January 2021, the Chief Nursing Officer (CNO) at Scottish Government outlined a 4-year funding plan to further develop and enhance community nursing teams.

This funding is intended to support the creation of additional community nursing posts, based on a recommended increase of 12% in the WTE establishment figure. The 12% growth figure was devised from the national modelling exercise undertaken in 2018 and consists of: Locally in Fife, the aim would be to build on current workforce strengths and enhance the capacity and capability further by creating progressive career pathways within community nursing from Band 3 – 7 and advanced practice opportunities to strengthen leadership.

Inpatient Nursing (East)

- Workforce: undertake workforce tool to inform safe staffing requirements (short)
- New models of care: i.e. Home First (short); Moving On policy ensuring discussions are commenced on admission
- Neuro rehabilitation: redesign and alignment of services within 18 months (medium)

Inpatient Nursing (West)

- Workforce: undertake workforce tool to inform safe staffing requirements (short)
- New models of care transfer:
- Test of change for Stroke (anticipated Oct 2021)

Fife Specialist Palliative Care

- Reassess and review Day-service model
- Inpatient / outreach service delivery model to ensure person-centred approach
- Continue to work in partnership with community services and 3rd sector partners

ICASS/ICT/Community OT

- Remodelling for Day Hospitals
- Greater integration of frailty services
- Development with Fife Council Housing Occupational Therapy to integrate into the Community Occupational Therapy service
- Working with Housing on One Stop Shops

Integrated Complex & Critical Care Services

2022 promises to be an exciting time for the range of services that fall within the Complex and Critical Care portfolio, with an ambitious agenda for expansion and improvement of services, ensuring more responsive access for new and current service users. During 2022 we will be taking forward the following priorities:

Social Work

The HSCP has recently invested in the Social Work Contact Centre to provide additional capacity whilst we creatively design new ways to deliver the best possible care and support at the front door.

Test of Change - Neurodevelopmental Pathway

In partnership with Education, Children's Services and NHS, a partnership approach is being rolled out across the schools in Fife to support early intervention and more immediate support to children affected by neurological disorders. An evaluation part-way through the year will allow us to consider the feedback from children and families, plus all agencies involved in the delivery, to improve the model before expanding it to be Fife wide.

Mental Health Services

Recognising the impact that the Covid-19 pandemic has had on the mental health and wellbeing of the population the HSCP has recently agreed to review and refocus the Fife Mental Health strategy, with a far greater focus on population wellbeing and ensuring that the range of access points to support and assistance are easily accessible, local, and responsive. It is anticipated this will be a focussed piece of work with our stakeholders, with a refreshed strategy available by April 2022.

Alongside this, the Scottish Government has awarded Fife HSCP significant additional funds for a range of services within the Mental Health family, which will enable us to increase the amount and accessibility of services. Some of the areas that are being developed to date include:

- Post Diagnostic Support for people with Dementia
- Psychological Therapies
- Children and Adolescent Mental Health Services
- Service to people experiencing Eating Disorders
- Unscheduled Care - access to Mental Health assessment and support 24/7

We will continue to develop our relationships with our 3rd sector and independent provider colleagues to maximise the range of services available throughout the localities of Fife.

Services to people with Addictions

Addiction services in Fife already support nearly 2,000 people in recovery. There is a wide range of work underway within this area, including:

- Implementation of the Medication Assisted Treatment standards
- Continued roll out and increased availability of Naloxone to mitigate the effects of overdose, and reduce drug related deaths
- Introduction of new medications which support independence from services, requiring less frequent appointments, freeing up, in a managed way, both the individual and capacity within the service.

Social Care Services

Community Support Services which offer community-based support to individuals with a range of needs, including people with learning disability, began a review of the delivery model before the on-set of the Covid-19 pandemic. Whilst only now being able to re-start, and with a renewed energy and focus, this will be taken forward with the participation of stakeholders and concluded within 2022.

Housing Support and Supported Accommodation

This service continues to provide a range of support arrangements enabling people to live independently, with support as required. This includes developing a range of models of care to ensure people with support needs, including those with complex needs, can be supported to live as visible contributing members of their community.

Glossary of Terms (A-Z)

Care - Medical, mental, emotional or practical support that is given to groups or individuals including ill health, disability, physical frailty or a learning disability, so they can participate as fully as possible in society.

Carer - Someone who looks after family, partners or friends who are ill, frail or have a disability. The support they provide can be paid or unpaid.

Community Care - Care for people who are ill, elderly, or disabled, which is provided within the community rather than in hospitals or institutions. The preference is to support people in the community, especially in their own homes, where possible.

Community engagement - Community engagement refers to the process of getting communities involved in decisions that affect them. This includes the planning, development and management of services, as well as activities which aim to improve health or reduce health inequalities.

Day Care - Extra care at a day centre to help someone who normally lives at home, by providing care, social contact opportunities and, where applicable, respite.

Enablement - Time-limited support services that aim to help people learn or re-learn the skills necessary for daily living. Can also be referred to as Intermediate care which is used to describe a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living.

Family Nurture Approach - brings together services from NHS Fife, Fife Council and the Third Sector, to work in partnership to support families and give children the best start in life.

Financial Recovery Plan - Plan to bring expenditure in line with budget.

HSCP - Health & Social Care Partnership.

Home Care - Home care (or home help) involves someone coming into your home to help you with personal care, like dressing or washing.

ICASS - Integrated Community Assessment and Support Service. This team of Healthcare Professionals and Support Workers who provide a range of integrated services in your own home, care home or community settings and is made up of two main parts that work very closely together.

IJB - Integration Joint Board.

Independent Sector - private companies or organisations of varying sizes from single providers, small and medium sized groups to national providers.

Integration - Combining. In this case, it means health and social care services working closer together to help achieve better outcomes for individuals and communities in Fife.

ISD - Information Services Division is part of NHS National Services Scotland. ISD provides health information, health intelligence, statistical services and advice that supports the NHS in progressing quality improvement in health and care.

MCCN - A Managed Clinical and Care Network enables professionals, public representatives and organisations to work together to promote consistency and quality of service throughout a person's experience of care.

Partnership - Way of working where staff at all levels and their representatives are involved in developing and putting into practice the decisions and policies which affect their working lives.

Pathway - A way of achieving a specified result; a course of action.

PDS - Post Diagnostic Support.

Person Centred - Person Centred is an approach to working with people which respects and values the uniqueness of the individual and puts the individual's needs and aspirations firmly at the centre of the process.

Personal Care – supporting activities in daily living such as being able to get in and out of bed, prepare a meal, bathe, and move safely around the home.

Provisional Outturn - The outturn is the actual net expenditure for the financial year, this is provisional until the external auditors have audited the annual accounts.

Reduce risk - Take action to control the risk either by taking actions which lessen the likelihood of the risk occurring or the consequences of occurrence.

Resources - People, money, buildings and equipment.

Risk - The chance of something happening that will impact on the organisation's ability to achieve its objectives.

Self Directed Support - Self Directed Support describes an arrangement where the service user arranges some or all of their support instead of receiving directly provided services from local authority social work or services or equivalent. Self Directed Support allows people more flexibility, choice and control over their support so that they can live at home more independently.

STAR (Beds) - Short term Assessment and Reablement Bed.

START - Short Term Assessment and Reablement Team.

Strategic Plan Themes - What we intend to take forward and how we shall respond to the issues.

Telehealth care - Telehealth care is a term used to describe a range of equipment used to support people in their own homes such as a community alarm, movement sensors, smoke alarms.

Third Sector - comprising community groups, voluntary organisations, charities, social enterprises, co-operatives and individual volunteers.

Voluntary organisations - includes registered charities, housing associations, credit unions, community interest companies, trusts and local community groups.

Appendix 1

National Indicators

ID	Indicator	Previous period	Latest period	Previous period Figure Fife	Latest period Figure Fife	Comparison to Previous Period Fife	Latest period Figure Scotland	Fife - Latest Period Compared to Scotland
1	Percentage of adults able to look after their health very well or quite well	2017/18	2019/20	93.60%	92.60%	1.00%	92.85%	0.25%
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	2017/18	2019/20	82.18%	77.57%	4.62%	80.78%	3.21%
3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	2017/18	2019/20	74.26%	73.38%	0.88%	75.43%	2.05%
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	2017/18	2019/20	74.89%	72.99%	1.90%	73.51%	0.52%
5	Total % of adults receiving any care or support who rated it as excellent or good	2017/18	2019/20	81.12%	81.61%	0.48%	80.15%	1.45%
6	Percentage of people with positive experience of the care provided by their GP practice	2017/18	2019/20	80.51%	74.73%	5.77%	78.74%	4.00%
7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	2017/18	2019/20	79.60%	80.54%	0.94%	80.03%	0.52%
8	Total combined % carers who feel supported to continue in their caring role	2017/18	2019/20	32.49%	34.29%	1.80%	34.28%	0.02%
9	Percentage of adults supported at home who agreed they felt safe	2017/18	2019/20	83.98%	82.46%	1.52%	82.79%	0.33%

ID	Indicator	Previous period	Latest period	Previous period Figure Fife	Latest period Figure Fife	Comparison to Previous Period Fife	Latest period Figure Scotland	Fife - Latest Period Compared to Scotland
11	Premature Mortality Rate per 100,000 population	2019	2020	414	422	8	457	36
12	Rate of emergency admissions per 100,000 population for adults	2019/20	2020/21	13,210	11,369	1,840	10,948	421
13	Rate of emergency bed day per 100,000 population for adults	2019/20	2020/21	122,242	97,029	25,212	99,456	2,427
14	Readmissions to hospital within 28 days of discharge per 1,000 discharges	2019/20	2020/21	111	115	3	120	5
15	Proportion of last 6 months of life spent at home or in a community setting	2019/20	2020/21	88.24%	90.96%	2.72%	90.30%	0.66%
16	Falls rate per 1,000 population (65+)	2019/20	2020/21	27.23	26.41	0.82	21.91	4.50
17	Proportion of care and care services rated good or better in Care Inspectorate inspections	2019/20	2020/21	82.38%	85.20%	2.82%	82.49%	2.71%
18	Percentage of adults with intensive care needs receiving care at home	2019	2020	57.89%	61.29%	3.40%	62.90%	1.62%
19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	2019/20	2020/21	714.73	569.73	145.00	488	81.32
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	2019/20	2020/21	26.07%	21.42%	4.65%	20.62%	0.80%

Indicators 1 to 9 – Health and Care Experience Survey

It was previously noted that the 2019/20 Health and Care Experience survey results released in the Core Suite Integration Indicators may differ from those published by the Scottish Government due to changes in the underlying methodology. These changes affect indicators 2, 3, 4, 5, 7 and 9 and mean 2019/20 figures are not comparable to previous years.

National MSG Indicators (Ministerial Strategic Group for Health and Community Care)

ID	Indicator	Previous period comparator	Latest period available	Previous period Figure Fife	Latest period Figure Fife	Comparison to Previous Period Fife
MSG 1a	Emergency Admissions*	2019/20	2020/21	44,246	36,362	7,884
MSG 2a	Number of unscheduled hospital bed days; acute specialties*	2019/20	2020/21	266,571	209,321	57,250
MSG 3a	A&E Attendances	2019/20	2020/21	97,962	68,513	29,449
MSG 4	Delayed Discharge bed days	2019/20	2020/21	41,735	29,970	11,765
MSG 5a	Proportion of last 6 months of life spent at home or in a community setting**	2019/20	2020/21	88.30%	91.11%	2.81%

* Data completeness for emergency admissions and bed days for Fife is 98% as at March 2021
** Provisional estimate as may be affected by data completeness

Appendix 2

Financial Information 2018 – 2021

Delegated Services (as at 31 March)	2018			2019		
	Budget	Provisional Outturn	Variance	Budget	Provisional Outturn	Variance
Objective summary	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Community Services	93.001	92.237	-0.764	97.812	93.586	-4.226
Hospitals and Long-Term Care	49.256	54.51	5.254	52.867	55.259	2.392
GP Prescribing	72.227	75.744	3.517	72.293	74.448	2.155
Family Health Services	86.641	86.627	-0.014	93.005	92.911	-0.094
Children's Services	15.035	13.715	-1.32	15.37	14.897	-0.473
Social Care	193.333	195.501	2.168	196.627	206.252	9.625
Housing	2.078	2.078	0	1.574	1.432	-0.142
Total Health & Social Care	511.571	520.412	8.841	529.548	538.785	9.236

Delegated Services (as at 31 March)	2020			2021		
	Budget	Provisional Outturn	Variance	Budget	Provisional Outturn	Variance
Objective summary	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Community Services	107.695	102.295	-5.400	123.319	120.719	-2.603
Hospitals and Long-Term Care	54.839	57.197	2.358	56.000	56.666	0.566
GP Prescribing	73.807	73.799	-0.008	70.979	70.955	-0.024
Family Health Services	99.765	99.749	-0.016	103.878	104.367	0.489
Children's Services	17.544	17.077	-0.467	18.202	16.913	-1.289
Social Care	204.635	214.814	10.179	234.675	239.356	-2.861
Housing	1.665	1.656	-0.009	1.324	1.324	0.000
Total Health & Social Care	559.95	566.589	6.639	617.384	610.300	-7.083

Alternative Formats

The information included in this publication can be made available in large print, Braille, audio CD/tape and British Sign Language interpretation on request by calling 03451 55 55 00.

Language lines
خط هاتف اللغة العربية: 03451 55 55 77
বাংলায় আলাপ করার জন্য টেলিফোন লাইন: 03451 55 55 99
中文語言熱線電話: 03451 55 55 88
Polskojęzyczna linia telefoniczna: 03451 55 55 44
اردو زبان کے لیے ٹیلیفون نمبر 03451 55 55 66

Fife Council and NHS Fife are supporting the people of Fife together through Fife's Health and Social Care Partnership. To find out more visit **www.fifehealthandsocialcare.org**

Fife Health & Social Care Partnership